

**ELECTIVE BREAST SURGERY AND BODY IMAGE:
A POSTSTRUCTURAL-PHENOMENOLOGICAL INVESTIGATION**

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ABSTRACT

This dissertation examines what happens when elective breast surgery intervenes on women at the level of their body images. In this theoretical-empirical project, I compare practitioner discourses and patient narratives of the impact of breast augmentation and reduction surgeries on female body image. To this end, I conducted two case studies: first, a feminist-poststructuralist discourse analysis of practitioner-authored studies on elective breast surgery and body image, as published in peer-reviewed journals; and second, a feminist-phenomenological inquiry into women's first-hand accounts of their experiences of these surgical procedures. I argue that body image is, at one and the same time, an uncritically accepted concept that encourages normative understandings of surgical outcomes and a productive lens through which women make sense of how surgery instigates a reorientation of the body and its habits. The unique contributions of this project are that it brings together poststructuralism and phenomenology so as to concurrently examine practitioner and patient perspectives of the effects of surgery, and critically examines the mainstream notion and widespread acceptance of "body image."

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CHAPTER 1: INTRODUCTION

The Rise of Body Image

The notion of “body image” has become deeply embedded in the way that we talk about aesthetic standards in Western societies and in the way we make sense of our feelings towards our bodies. Interest in body image proliferated in the 1970s, when feminists denounced dieting and unrealistic beauty standards and psychologists began to measure people’s perceptions about the size and shape of their bodies. Since then, body image has become a predominant and mainstream concept for understanding why women and girls in particular engage in dieting, excessive exercise, disordered eating, wearing makeup, body modification, and aesthetic surgery. When women and girls participate in such practices, we are said to exhibit, to some degree, “negative” body image—a critical attitude toward our bodies and/or a dissatisfaction with our physical appearance. The issue of negative body image is considered to be so pervasive in Western society and culture that it has been labelled a “normative discontent” (Thompson cited in Markula 2001, 170). “A discourse of body image problems,” writes Sylvia Blood (2005), “is woven into the fabric of our everyday experience” (1). Non-profit organizations like the National Eating Disorders Association (NEDA) and the Social Issues Research Centre (SIRC) publish resource sheets that explain body image issues and offer exercises that women and girls can try to improve their body image and self-esteem. For more than a decade, body image has been at the forefront of numerous self-esteem and empowerment campaigns directed at women, who are said to be disproportionately affected by negative body image.

Female body image has also been the focus of brand marketing campaigns targeting female body- and self-esteem. In 2004, Dove launched its Campaign for Real Beauty as well as its Self-Esteem Project, both of which aim to promote body confidence and self-esteem in girls

and young women. The Dove Self-Esteem Project is a web-based initiative that hosts educational resources that parents, adult women, and youth leaders can use in teaching young women and girls about body confidence and positive self-esteem. Dove's mission is to empower young women and girls towards body- and self-acceptance so that concerns over appearance do not impede their aspirations, accomplishments, or enthusiasm for life. In 2013, Special K cereal, taking inspiration from Dove, launched a similar advertising campaign targeting negative body image. The Special K campaign suggested that women stop engaging in “fat talk”—the act of making disparaging comments about their bodies—and to discourage other women from engaging in “fat talk.”¹ The problem of “negative” body image and the promotion of “healthy” body image are sources of concern for health care practitioners, researchers, health and wellness organizations, personal care and food manufacturers, and mass and social media outlets.

Body image issues are also, and significantly, of concern to individual women who deal with poor self-esteem and/or body confidence. Every year, we are told, thousands of women engage in weight loss programs and/or body modification practices in order to deal with their body image issues (Sarwer, Grossbart and Didie, 2002). Some practices, specifically elective surgical and non-surgical procedures, are undertaken with increasing frequency as an “adaptive strategy to address body image dissatisfaction” (Sarwer and Crerand 2004, 107). But, how exactly does aesthetic surgery “address” problems of body image? What kinds of effects does aesthetic surgery have on “body image” as a concept and as a quality of the subject? Are there

¹ Special K suggested that fat talk is “a barrier to weight-management success” (cited in Faircloth 2013, n.p.). Journalists, activists and scholars took this and the Dove campaign to task for several reasons, one of which is their failure to recognize the ways in which the message of body confidence relied upon and encouraged continued consumerism without recognizing that consumer culture causes the very problems these campaigns are trying to “fix.” Josée Johnston & Judith Taylor (2008) argued that the Dove Campaign promotes a form of “feminist consumerism” in which “beauty and self-acceptance can be accessed through the purchase of Dove beauty products” (962). Special K's campaign attracted similar criticism. Feminist blogger Kelly Faircloth (2013) pointed out that Special K has, from its inception, been marketed as a weight-loss product. (Notably, the brand frequently advertised the Special K Challenge, and boasted that women who followed the nutrient-poor diet plan could drop “a jeans size in 2 weeks.”) While the two Dove campaigns continue to this day, Special K discontinued its campaign.

differences in how these effects are articulated by patients and by practitioners? This dissertation investigates what happens when elective surgical procedures address the matter of female body image.

Lived Bodies, Elective Surgery and Contemporary Biomedicine

In the contemporary Western moment, it is rare that surgery—whether aesthetic or medically necessary—is solely a matter of treating illness or disease, alleviating physical discomfort, or repairing a bodily “anomaly” (Schlich 2010a). Surgical intervention has, for a long time, been entangled with the production of normative bodies in relation to sex, sexuality, and gender expression. The fact that women are disproportionately targeted for surgical intervention is especially well-established by the case of aesthetic surgery as an extension of beauty regimes (Balsamo 1992; Bordo 1993; Heyes 2007a, 2007b; Morgan 1991; Weiss 2014). But, even before the advent of aesthetic procedures, women were disproportionately exposed to surgery. For example, women were targeted in the development of organ transplantation (Schlich 2010b) and the myriad surgical procedures that established gynecology (Dally 1991). After modern aesthetic surgery established itself in WWI and WWII as legitimate, it became useful for “improving” the appearance of bodies (Serlin 2004) and has since been integral in the determination and regulation of the morphological organization and aesthetic appearance of female bodies in particular. Today, women remain the primary consumers of aesthetic surgery and we are, in turn, the focus for the development of new and increasingly precise procedures such as labiaplasty and other forms of genital aesthetic surgery (Braun 2005; Rodrigues 2012a; Tiefer 2008). A majority of empirical and theoretical investigations of surgery, at least in the social sciences and humanities, are and have been primarily conducted by feminist thinkers interested in the implications of aesthetic surgery for expressions of embodiment and subjectivity

in a patriarchal context. This work has been anchored by a poststructuralist, Foucaultian framework that interrogates the relations of power that inform and are embedded in women's engagement with aesthetic surgery and beauty practices (e.g., Bartky 1990; Bordo 1993; Morgan 1991; Covino 2004; Jones 2008; Heyes 2007a).

Feminist engagements with aesthetic surgery offer a critical perspective on the implications that elective and aesthetic surgeries have for how we, as women, understand and live in our bodies. In particular, feminists have focused on how the medicalization of female bodies, body parts, and sexualities (Ehrenreich and English 1973; Kohler Riesman 1983; Lupton 2003; Mamo and Fosket 2009; Tiefer 2008) has instigated a socio-cultural discourse in which undergoing elective (non-emergency) surgical procedures has become tantamount to the expression of a woman's choice, willfulness, empowerment, and subject formation (Braun 2009; Davis 1998; Fraser 2003; Gillespie 1997; Heyes 2007a; Morgan 1991; Tiefer 2008). The discourse around the management of human well-being and health via elective surgery is frequently wrapped up in conversations about individual choice and personal responsibility. In a context in which discourses of medicalization communicate to us the kind of subject we ought to imagine and desire ourselves to be, electing surgery for reasons of health and/or appearance comes to indicate a particular kind of self whose motivations and, in turn, choices emerge intrinsically from the individual but nonetheless produce homogenized results because aesthetic standards are dictated by patriarchal culture (Balsamo 1992; Heyes 2007a, 2009). Women's engagement with elective surgery is positioned in terms of its relation to socio-culturally entrenched ideas about aesthetics, individuality, and agency, but feminist theorists also note that individual women also consider their interaction with surgery against its potential impact and

effect at the level of the body and at the level of embodiment (de Boer, van der Hulst and Slatman 2015; Slatman et al. 2016; Uçok 2005).

Building on this scholarship, this dissertation project investigates the implications of elective breast surgery for discourses and experiences of embodiment in relation to female body image. Specifically, this project takes up adult women's encounters with breast augmentation and breast reduction alongside studies of how health care practitioners communicate their understanding of this encounter in articles published in peer-reviewed health and life sciences journals. Through the notion of "body image," this dissertation demonstrates that elective breast augmentation and reduction surgeries inform and are informed by normalizing discourses on female body experience and embodiment but are also a site upon which distinct and idiosyncratic articulations of female body experience and embodiment can be articulated. Elective surgical procedures carried out on women's breasts are a useful point of inquiry in part because, as will be outlined briefly below and in more detail in Chapter 2, breasts have been made so significant in and to a woman's body and self-image in the contemporary Western context. Moreover, breast augmentation and breast reduction are but two procedures that demonstrate the relative ordinariness of elective surgery on women's bodies. Both procedures are positioned as routine in at least two ways: first, they are primarily scheduled as outpatient procedures that do not require overnight hospital stay;² second, they are routine and frequently performed procedures. According to the most recent statistical report of the American Society of Plastic Surgeons, 279,143 of the 1.7 million cosmetic surgical procedures performed in 2015 were breast augmentations, making it the most common aesthetic surgery (ASPS 2015). Breast reduction is,

² Bisher AlShanawani et al. (2013) point out that it is only recently that breast reduction procedures became primarily outpatient. They indicate that better pain treatment and improvements in technique that consequently reduce blood loss have expedited patient discharge.

by comparison, uncommon: in that same year, only 40,650 breast reduction procedures were performed on women (ASPS 2015). Bisher AlShanawani et al. (2013) find that an average of 5121 breast reduction procedures are performed annually in Ontario and that the average rate of breast reduction procedures in Ontario is 86.2 per 100,000 women annually.

This dissertation project considers the effects of elective surgery on the body and embodiment by comparing discursive and lived articulations of the outcomes of elective surgery for and in terms of body image. In particular, this project focuses on women's encounters with elective breast augmentation and reduction surgeries and specifically investigates the impact of these procedures on female "body image," by examining how women and health care professionals conceptualize and articulate the impact of these surgeries on female bodily awareness, aesthetics, sensations and possibilities. Elective breast augmentation and breast reduction are two procedures that are, given the site on which they take place, especially caught between individual health and cultural aesthetics: initially motivated by concerns for individual well-being, such surgeries are undergirded by an awareness of and motivation to produce aesthetic standards. In this dissertation, the growing collapse between concerns for health and interest in normative aesthetics runs as an undercurrent; this project's findings suggest that elective surgery functions first as an apparatus of production—of subjects, subjectivity, and particular modes of embodiment—and second as a mechanism of tension that continually is caught in and reproduces the frictions between normalization and individual self-making, appearance and function, and aesthetics and reconstruction.

Because the aspirations of elective surgery have, historically and in the contemporary moment, frequently been informed by the aesthetic and functional "improvement" of female bodies, procedures such as breast reduction are, for many women, not only about their well-

being but also about the relationship between “corporeality, gender identity, and sexual expression” (Manderson 2011, 174). Considering the corporeal site on which they take place, breast reduction and breast augmentation are entangled with the markings, makings, and meanings of sex, sexuality and gender. Female breasts have long been positioned as the primary signifier of womanliness as well as a primary site for the objectification of female bodies and sexualities. This long-standing association of breasts as the markers of femaleness, femininity, and female sexuality means that our understandings, experiences, representations of and discourses on breast surgeries will always already be entangled with the social-cultural construction and representation of female breasts as vital determinants of femaleness and femininity (Jacobson 2000; Manderson 2011; Young 2005). As a starting point, this project assumes that the decision to undergo elective breast surgery is motivated by a specific orientation towards one’s breasts that is not so easily extracted from the socio-cultural positioning of female breasts and breastedness in Western culture. It is not an objective of this project to make a contribution to extant commentary on the meanings and significance of female breasts in the Western socio-cultural-industrial context, given that this work has been established well elsewhere and earlier (Jacobson 2000; Millsted and Frith 2005; Wolf 1997; Young 2005); however, because female breasts are of course so significant to both the context in which breast reduction and augmentation are carried out and to women themselves, this is necessarily an undercurrent of this project. As such, a sustained acknowledgement of the significance of female breasts in the West is taken up in Chapter 2.

Project Objectives and Research Questions

The overarching interest of this dissertation is to open up for serious consideration the ways the physical and experiential outcomes of elective surgery influence both individual and

professional articulations of female body image and embodiment. With respect to embodiment, this project considers both the theoretical conceptualization and lived experience of embodiment; that is, it considers the interactions and relationship between the objective, institutionalized body and the sensual, subjective body (Howson 2005, 2013). Embodiment is a complex phenomenon that is “simultaneously...constructed through social contexts and power relations” as well as “lived experience” (Del Busso and Reavey 2013, 47, 50). Embodiment theory recognizes that the body is not a static object, and that embodiment is more than simply the vehicle for experience or a series of mechanical processes. The body is “my point of view, and my way of experiencing and understanding of the world” (Svenaeus 2013, 100). This dissertation focuses on how we *are* our bodies in an almost “post-surgical” context wherein, as implied above, elective surgery is an accepted and acceptable form of body care. The results of this study suggest that our understanding of what the body is, means, can be, and can do in contemporary Western culture has undoubtedly been shaped by the institutionalization and widespread acceptance of elective surgery as a form of self- and body care.

This project takes up and examines the relationship between elective breast surgery and female embodiment by focusing specifically on how the discourses of and actual changes provoked by elective breast surgery determine and/or contravene women’s sense and understanding of what our bodies can be, feel, feel like, and do. This engagement with the lived possibilities of and feelings toward the body is examined through a comparative engagement with clinical discourses and women’s narratives of body image in the context of elective breast augmentation and reduction. The notion of body image, which is articulated in Chapters 2 and 3, has become a routine aspect of how people talk about their relationships with their bodies and is at the forefront of campaigns to improve women’s self-esteem and body confidence. As

discussed in Chapter 3, it is also the subject of a significant amount of clinical research. The understanding of body image that informs research and popular thinking has its conceptual origins in psychological and neurological research which established the concept as it is currently articulated (Head 1926; Head and Holmes 1911; Schilder 1950). Importantly, body image also has roots in phenomenological inquiry where it is theorized as body image or “body schema” (Merleau-Ponty 2013).³ Yet, the phenomenological origins of body image remain under-acknowledged in both popular cultural and scholarly discussions of body image, despite its ongoing theorization and retheorization by phenomenologists (Butnaru, 2013; Lymer 2015). As a result, critical investigations of body image do not consider the psychological and phenomenological ideas about body image in tandem; however, there have been recent calls to reintroduce the psychological and phenomenological concepts of body image (Barina 2015). This project is anchored by the concept of body image(s) as it has developed in phenomenology (Grosz 1994; Merleau-Ponty 2013; Schilder 1950; Weiss 1999) *and* in psychology (Blood 2005; Cash 2008, Cash and Smolak 2011; Grogan 2008). A central conceptual and methodological innovation of this dissertation project is to bring together these interrelated, though not synonymous, articulations of body image in order to generate an opportunity to reconsider these concepts, think critically about our understandings of the available possibilities we hold and have for our bodies, and reexamine how the bodily change instigated by elective surgery can shift, limit, and/or open up our sense and sensation of bodily and embodied possibility.

The theoretical framework for this project, which is outlined briefly below and in more detail in Chapter 2, aligns poststructuralist, phenomenological, and feminist theories of the body in order to consider how elective breast reduction and breast augmentation surgeries impact what

³ The distinction and overlap between body image and body schema is discussed in more detail in Chapter 2 and Chapter 5.

it means for women to be, be in, feel, feel with and do a body in a socio-cultural context that routinizes surgical intervention on our bodies. In implementing a clustered theoretical lens, this project takes up the myriad ways in which bodily change created by surgery, particularly when encountered within Western biomedicine, affects women's sense and awareness of their body image(s). With this theoretical grounding in mind, I argue that (bio)medicalized surgical practice interacts with, understands, influences, and takes responsibility for female bodies, body practices, and embodiment through a particular curation of both body *and* body image. In addition, I suggest that women who have experienced breast augmentation or reduction overwhelmingly articulate shifts in their relationship with their body image(s) that reconfigure and recreate their relationship to the body, body practices, and embodiment. To this end, the primary research questions that inform this project are as follows:

- 1) How does biomedicine—which privileges the physical body at the expense of social, psychological, environmental and behavioural factors—understand and operationalize the idea of “body image,” and, comparatively, how does bodily change created by biomedical surgical intervention affect women's sense, awareness and articulation of their body image?
- 2) What does body image come to mean and signify when articulated in biomedical discourses about elective breast surgery? How do “experts”—including surgeons, nurses and other health care practitioners—make sense of body image when reporting on and evaluating patient experiences and outcomes?
- 3) What is the lived experience of elective surgery as a phenomenal event? In what ways does elective surgery affect women's bodily and embodied experiences in Western

culture? How do women's experiences of breast augmentation and reduction both support and transgress the normativizing logic of biomedicine?

- 4) How might the reorientation and/or reorganization of the body by elective breast surgery transform both the theoretical understanding of the "body image" as well as its lived possibilities, considering that our body image(s) expresses our way or style of being in the world? How does elective surgery impact women's conceptual or felt sense of what is possible and conceivable for one's own body and for "the" body?

In order to respond to these questions, this project examines the relationship between elective breast surgery and embodiment in terms of both medical discourses on *and* first-hand patient experiences of breast augmentation and breast reduction in terms of how these procedures intersect with the notion of the "body image." The project compares and contrasts body image discourse in clinical publications on breast reduction and breast augmentation with how women articulate their own experiences of body image in the context of these two procedures. In paralleling these two sets of discourses, the project considers the effects and impact of surgery in a manner that considers how discourses, practices and institutions of power, such as biomedicine, manage and modify corporeal processes and performances (Foucault 2003d, 1990) alongside an apprehension and articulation of the lived body and subject as they are situated within this particular milieu (Merleau-Ponty 2013).

Theoretical Framework and Analytical Approach

Poststructuralism and Phenomenology: Assembling a Dual Theoretical Framework

This project combines empirical research with theoretical inquiry in order to consider the broader significance of the clinical publications and interview texts in terms of the socio-cultural relations of power as well as the intersections between theoretical inquiry and lived experience. This project is informed by and interweaves Michel Foucault's poststructuralism with Maurice Merleau-Ponty's phenomenology. Pairing poststructuralism with phenomenology makes sense, given that both frameworks are fundamentally philosophies of the body (Crossley 1994; Diprose 2005).⁴ Because elective surgery on women's bodies is a feminist issue, as described above, and because feminist thinking has challenged, expanded, and deepened the frames of poststructuralism and phenomenology, I also draw in this project on feminist theoretical work on the body, embodiment, and body practices. Intertwining these two theoretical lenses and intersecting them with their feminist interlocutors enables a comparable consideration of object bodies and lived bodies.

Poststructuralism is often characterized in terms of its refusal of objective certainty, essential experience, and grand narratives. In particular, it is concerned with how we, as subjects, are interpellated by society to internalize, submit and conform to its values and account for ourselves on the basis of those values.⁵ Foucault is connected to poststructuralism insofar as his work engages not only the history of concepts but also the way that the use and deployment of

⁴ There is much discussion and acknowledgement of the inherent intellectual disagreement between poststructuralism and phenomenology (both by Foucault himself and in the broader literature) (Alcoff 2000; Crossley 1994; Gutting 1990; Lawlor 2014; Levin 2008; Oksala 2004; May 2005). I take up this matter in Chapter 2 and return to it in Chapter 5.

⁵ This is in opposition to structuralism, which seeks to uncover "objective laws that govern all human activity" (Dreyfus and Rabinow 1983, xix).

concepts in language defines and maintains institutions (Gavey 1989; Gutting 1990).⁶ A poststructuralist orientation to knowledge asserts that “all meaning and knowledge is discursively constituted through language and other signifying practices,” to the extent that “language (and discourse) *constitutes* subjectivity” (Gavey 1989, 463, emphasis in original). Further, embedded in the poststructuralist account of the subject is an ambiguity, insofar as the subject is both an agent who initiates action *and* a position subjected to social meanings and norms. Foucault’s work, especially in its reference to Louis Althusser, demonstrates the operation of “agreed-upon examples of how a domain of human activity should be organized” that, in turn, “show us how our culture attempts to normalize individuals through increasingly rationalized means, by turning them into meaningful subjects and docile objects” (Dreyfus and Rabinow 1983, xxvii). In this respect, Foucault focuses specifically and uniquely on the body as the site where micro-level social practices connect to the macro-level organization of power; some thinkers maintain that this is his central contribution to contemporary thought and practice (Dreyfus and Rabinow 1983).

In particular, Foucault interrogates the production of truth as it functions vis-à-vis social, juridical, and sexual norms and the regulation of bodies under power relations that are reinforced by the institutions that prescribe and reinforce such norms. Foucault’s engagement with institutions of power considered the church, the hospital, and the asylum, among others. His analysis of power, by far his most recognizable theoretical contribution, shows that power is not merely the act of one party having a relation of domination and control over the other. Rather, Foucault understood power as a network marked by: a series of unbalanced, heterogeneous,

⁶ Dreyfus and Rabinow (1983) caution against positioning Foucault as a poststructuralist (or structuralist) particularly because of his shifting methodological approaches and conceptual concerns, but they acknowledge a certain alignment with his project and the poststructuralist project writ large, as do many other contemporary thinkers who typically position Foucault as poststructuralist or postmodern.

unstable, tense “force relations” operating in a particular context; a process that works counter to force relations to reverse them; something that upholds or dismantles a larger system of force relations; and something that is omnipresent, not because it exerts itself over everything, but because it originates from everywhere and thus is always being produced in moments and relations (Foucault 1979, 1990).

Merleau-Ponty’s phenomenology is the second theoretical lens employed in this project, particularly where his thinking intersects with the lived body and its world. Phenomenology, for Merleau-Ponty (2013), is a philosophy that offers a direct description of our experience as it is, without appeal to the psychological or causal explanations that science, history, or sociology might offer. The task of phenomenological inquiry is, as Merleau-Ponty (following Edmund Husserl) articulates it, to uncover the mystery of the world and of reason. Phenomenology demands awareness, attention, wonder, and the will to grasp the sense of the world. To this end, Merleau-Ponty attends to and re-centres the body in order to demonstrate that the body is not merely a physical entity or object, as empiricist and intellectualist modes of thought contend. Perhaps most importantly, he affirmed that the body is essential to and for being-in-the-world, which is the unity of embodied consciousness with its milieu. Merleau-Ponty’s phenomenology demonstrates that the body is not a passive object for consciousness. Instead, the body is an “I can” that is endowed with an intentionality; in turn, it is through the body, and not solely consciousness, that one apprehends and communicates with the world as that which is co-constitutive of lived experience. The return to the body enables the unification of embodiment and consciousness, and ultimately reveals that embodiment is inextricable from the apprehension and thus lived experience of the world.

A poststructural-phenomenological approach to elective surgery, informed by feminist theorizing on the body, embodiment and body practices, engenders the conditions for the consideration of how biomedicine manages and modifies female corporeality and feminine performances in order to perpetuate the social regulation of bodies alongside an apprehension and articulation of the lived body and subject. Put another way, while a Foucaultian frame can account for the effects of power on individual bodies, it is oriented toward explaining how discourses of expertise are formed and historically change; it does not account for or investigate the effects of power upon the lived body. In contrast, Merleau-Ponty's phenomenology of the body offers the tools for analysis of the apprehension and articulation of the lived body as tied to a situated subject but his engagement with the intervention of objective and systemic power is limited. Therefore, a theoretical orientation that couples the poststructuralist lens with a phenomenological one generates a perspective that equally considers lived female bodies and object female bodies when and as they are subject to surgeries that take place in the context of biomedicalization. As Lisa Cosgrove (2000) notes, a social constructionist approach understands meaning to be "produced (or even policed) through discourses rather than revealed" by individuals or researchers; in contrast, a phenomenological approach "emphasizes the importance of the individual's lived world and the interpersonal realm in the constitution of identity" (258). In turn, a "connective strategy" that brings together poststructuralism and phenomenology makes it possible to account for discourse and agency as co-constitutive of experience and embodiment; it can also identify interdependencies and a common ground between concepts, in turn allowing for the formulation of interstitial concepts and problems (Crossley 1994). However, there are recognized tensions between poststructuralism and

phenomenology, and these theoretical frameworks and tensions as well as recognized points of resolution are taken up in detail in Chapter 2 and returned to in Chapter 5.

Analytical Approach

Two data sets comprise the empirical materials that I examine in this project. One data set is composed of peer-reviewed articles about body image in the context of breast reduction or augmentation published in health and life sciences journals. They are written by health care practitioners, including aesthetic and reconstructive surgeons. The other data set comprises adult women's first-hand accounts of their experiences with either of these procedures, as narrated to me in semi-structured interviews. In order to analyze these two disparate data sets, I engage discourse analysis in the study of the clinical publications and thematic narrative analysis in the study of the interview texts. These analyses are driven by a theoretical interest in the conceptualization and mobilization of body image in discourse and lived experience as it is expressed in a particular social, political, cultural, and economic structure. I offer an analysis of these sets of texts as they pertain to the matter of body image and how it is produced and understood by and for women living in a heterosexist, capitalist, patriarchal context in which the surgical alteration of the body is not an uncommon practice.

Discourse analysis, when approached through a feminist, poststructuralist lens, is a tool for the critical analysis of texts and/or social practices that can identify what possibilities and subject positions are available to women "in a given culture and society at a given time" (Gavey 1989, 466). This kind of analysis understands "discourse" as an interconnected "system of statements which cohere around common meanings and values...[that] are a product of social factors, of powers and practices, rather than an individual's set of ideas" (Hollway, cited in Gavey 1989, 463-464). For feminist theorists, discourses offer women possibilities to constitute

their subjectivity, and discourse analyses identify the operation and effects of extant power relations as well as opportunities for resistance (Wheeldon 1987). Nicola Gavey (1989) notes that discourse analysis involves the close reading of texts at the level of “detail in language” and the “wider social picture” so as to determine what “language processes people use to constitute their own and others’ understanding of personal and social phenomena” (467). Discourse analysis aims to offer nuanced accounts of a particular discourse or discursive pattern within the data as opposed to a rich, overall description and intends to demonstrate that the reports, statements, or accounts under examination are recognized as discursive productions and cannot be said to reflect “true” insight, opinion, or experience (Gavey 1989). Discourse analysis focuses on identifying what specific content a narrative communicates, as well as how that narrative references extant discourses, rather than on the structure of a given or certain narrative; thus, it focuses on “the told” rather than “the telling” (Kohler-Reissman 2008, 54). Discourses are more than systems of statements that get replicated in social or political contexts; discourses “exert normalizing and regulatory effects upon the individual subject” (Brown-Bowers et al. 2015, 325). As a result, it is important to clarify that this study focuses on what clinicians have to say about body image in the context of breast augmentation and reduction, in terms of what dominant knowledges and values are present and reproduced, as well as subject positions are considered to be and produced as available to women.

To conduct this discourse analysis, I broke down, compared, and categorized the clinical publications at the level of language and in relation to the research questions that inform this project. I focused first on identifying patterns of meaning and second on connecting identified patterns to extant and intersecting discursive and power structures. Open codes were recorded on the articles in the text itself, written next to the text that reflected the codes; relevant text was

highlighted and/or underlined. From there, I conducted axial coding in order to reassemble the data and establish connections between the categories identified in the open coding process (Lockyer 2004; Strauss 1987; Strauss and Corbin 1990). This was done by engaging a closer reading of each item, during which open codes were organized and clustered into descriptive themes that reflect what is shared across the texts. Quotes were extracted from the data set and organized such that each theme had evidence from the texts to support it. At this point, discursive themes were either reorganized, refined, condensed, or discarded; the texts were revisited until no new themes could be identified. The discourse analysis of the clinical publications is presented in Chapter 3; this chapter also contains an additional methodological clarification about my data collection and sorting methods.

Thematic analysis is a method for “identifying, analyzing and reporting patterns (themes) within data” in order to describe a particular data set in “rich detail” (Braun and Clarke 2006, 79). It is similar to but differs from discourse analysis in that, in this type of analysis, a “theme” is as such when it “captures something important about the data in relation to the research question and represents some level of *patterned* response or meaning within the data set” (Braun and Clarke 2006, 82, emphasis in original). There are a variety of ways to conduct thematic analysis. This project takes a theoretical, and latent approach to the interview texts that is oriented around and situated within a feminist-phenomenological framework. A theoretical approach is one that focuses on producing a detailed analysis of particular aspects of the data in relation to the research questions, while the latent approach identifies and examines “the underlying ideas, assumptions, and conceptualizations—and ideologies—that are theorized as shaping or informing the semantic content of the data” (Braun and Clarke 2006, 84). In addition, to an extent, I also considered the data from a constructivist perspective as it enables one to show

how “perspective, meaning, and experience are socially produced and reproduced,” rather than assuming that these are embedded within individuals; in turn, this approach can disclose experience alongside theoretical consideration of “the sociocultural contexts and structural conditions that enable the individual accounts that are produced” (Braun and Clarke 2006, 85).

I coded the interview texts against the overarching research questions that inform this project, reading and re-reading them for themes related to “body image” and coding diversely without attention to what themes might have been uncovered in previous research on the topic. My intention was to produce a number of themes around body image, which may parallel or add to those identified in previous research. In addition, I took an interest in the latent content of the data set, attending to dormant rather than manifest semantic content in order to identify and examine the underlying assumptions, conceptualizations, and ideologies that are then theorized as “shaping or informing the [manifest] semantic content of the data” (Braun and Clarke 2006, 84). In analyzing the interview texts, I followed Braun and Clarke’s (2006) six phases of thematic analysis and supplemented this process with guidance from key texts on coding qualitative materials. These phases are as follows: becoming familiar with the data; generating codes; searching for themes; reviewing themes; defining and naming themes; and reporting. First, each transcript was quickly read and re-read, with notes taken along the way in a notebook or in the margins to mark initial observations and generate open codes. An inductive approach was taken, in which codes emerged from the texts; in other words, codes were not imposed upon the data from existing theoretical frameworks or in an attempt to make the texts prove or disprove a hypothesis (Kirby et al. 2006; Strauss and Corbin 1990). The thematic analysis of the interviews is outlined in Chapter 4; this chapter also contains additional methodological clarification on participant sampling and data collection.

A Note on Terminology and Selection Criteria

I have made specific terminological choices and selections that serve particular purposes for the framing and execution of this project. First, when discussing breast augmentation or any surgical procedure done primarily to produce an aesthetic change, I shall employ the term “aesthetic surgery,” instead of the more common “cosmetic surgery.” I do this in order to affirm that this project does not take up surgical procedures that are reconstructive in nature. The relationship between “cosmetic” and “reconstructive” surgical procedures is a slippery one that is often misunderstood and in turn generally under-acknowledged in contemporary writing on elective surgery. For Sander Gilman (1999), “the history of aesthetic surgery evolves from a conscious or unconscious juxtaposition with reconstructive surgery” (12). He notes that the term “beauty surgery” first appeared in the 1840s, when Dr. Johann Dieffenbach used the term to distinguish aesthetic procedures from so-called legitimate reconstructive surgeries that addressed bodily injury or “abnormalities.” In the 19th century, “cosmetic surgery” began to appear sporadically, first in discussion and writing about reconstructive surgery, and then as its antithesis (Gilman 1999). Prominent surgeons, such as Harold Gillies, saw cosmetic surgery as subordinate to reconstructive surgery. In the early decades of the 20th century up until the end of WWI, cosmetic surgeons were positioned as “quacks” (Gilman 1999). This distinction between aesthetic or cosmetic and reconstructive surgery is maintained today, but now it informs where procedures are carried out (private clinic; public hospital) and how they are funded (privately; publicly) (Naugler 2009).

Second, this project explicitly focuses on surgical procedures that are considered “elective” or non-emergency. Elective procedures are not necessarily those procedures that are a matter of an individual’s choice; contrary to popular parlance, they are elective by virtue of the

fact that they are planned in advance and non-emergency in nature. Elective procedures may or may not be life-saving and may or may not have a connection to the patients' physical health and well-being. Thus, breast reduction and breast augmentation are both elective procedures. Yet, while breast augmentation and breast reduction are carried out on the same corporeal site, they remain categorically distinct at the levels of culture, society, biomedicine, and discourse. Breast augmentation is categorized as an aesthetic, non-medically necessary outpatient procedure carried out in private clinics in order to "enhance" the size and appearance of the breasts. In contrast, breast reduction, also an outpatient procedure, is typically categorized as a medically necessary procedure because it resolves the physical discomfort and functional limitations caused by disproportionately large breasts (e.g., back, neck, and shoulder pain; skin chafing; shoulder indentations). Women who have breast reduction typically have their procedure covered by state-level health care programs, while women who have breast augmentation are expected to cover their own costs. The fact that breast reduction is covered by state-level health care programs works to legitimize it as a medically necessary procedure.

Third, both breast augmentation and breast reduction procedures attend to women's breasts in a "healthy" state, and it is this shared characteristic that demarcates the limits for the scope of this project.⁷ The decision to focus on elective procedures aligns with my broader research program that has focused on the implications of elective surgeries, particularly aesthetic procedures (Rodrigues 2012a, 2012b). Practically, it is beyond the bounds of feasibility to consider the experiences of women who have breast surgery because they have pathological breast tissue (e.g., mastectomy or lumpectomy in cases of breast cancer). Elective breast

⁷ Elective breast augmentation and reduction are carried out on otherwise healthy breasts, but to state as much is not to suggest that there is no overlap or intersection between illness and elective breast augmentation and reduction. Given the pathologization of the body image issues and physical symptoms that frequently motivate the uptake of such surgeries, illness is absolutely relevant to this context and is addressed where relevant.

augmentation and reduction procedures are the focus of this study specifically because both procedures ask the patient or client for the same kind of engagement with the health care system: consultation, surgery, and (possible) post-operative follow-up. Women diagnosed with breast cancer often have a far more long-term, complex, and idiosyncratic engagement with the health care system, and surgery may only be one in a range of treatment options. Further, researchers often recruit such participants through their professional connections to research and teaching hospitals or representatives thereof (e.g., de Boer, van der Hulst and Slatman 2015; Ucok 2005). These projects typically comprise multi-year studies, and are sometimes conducted by multiple investigators who follow and engage with patients throughout the course of their treatment to ensure empirical results that represent the full range of experiences (e.g., Slatman et al. 2016). Indeed, the purposive and strategic sampling engaged in the present study not only affirm the manageability of the project but also ensure the comparability and compatibility of the interview texts and the articles that comprise the empirical materials.

Chapter Outlines

This chapter has introduced the context for this project, presents the major problematic, research questions, theoretical frameworks, methodology and contributions. Chapter 2, “Aligning Phenomenology and Poststructuralism Towards Theorizing Body Image and Elective Breast Surgery,” establishes phenomenology, poststructuralism, and their respective intersections with feminist theory of the body as the theoretical frameworks that inform this dissertation. It also reviews body image and body schema as the theoretical concepts that inform and are critically investigated through this project. The two chapters that follow from there each engage distinct empirico-theoretical analyses of body image in the context of elective breast surgery.

Chapter 3, “Body Image as Normalization: Clinical Discourses of Elective Breast Surgery,” comprises a Foucaultian poststructuralist analysis of the function and mobilization of “body image” in peer-reviewed clinical publications about breast augmentation and reduction surgeries. Here, I argue that “body image” is a normative concept that influences how surgical objectives and outcomes are discussed and understood. I also argue that clinical discourses on body image in the context of elective breast augmentation and reduction perpetuate a narrative of body image that works to justify and promote surgical intervention as an effective and appealing solution to body image “problems.” Chapter 4, “Open Embodiment: A Phenomenological Inquiry into Body Image and Elective Breast Surgery,” examines the relationship between elective surgery and female embodiment through the investigatory framework of phenomenology. This chapter presents the findings of my qualitative inquiry into women’s lived experiences of breast augmentation and reduction and draws out the relationship between body image and embodiment through an exploration of the results of semi-structured interviews with adult women who experienced these procedures. In this chapter, I disclose how and in what ways elective breast surgery provokes a shift in an individual’s conception of the lived body. I argue that the phenomenological notion of body image generates an opportunity to make manifest the ways that elective surgery summons and instantiates a reorientation of the body and its habits and reconfigures the body’s openness to the world.

In Chapter 5, “Object Body, Lived Body: The Impact and Implications of Body Image Narratives in Breast Augmentation and Reduction,” I compare and synthesize the findings of the two empirical chapters in relation to the ways that the biomedical deployment of body image and the phenomenological articulation of body image contribute to understanding how the possibilities for and of our bodies shift when they are reconfigured by elective surgical

intervention. I then consider what engaging a poststructuralist investigation of body image alongside a phenomenological investigation of body image reveals for the recognized tensions and intersections that exist between poststructuralism and phenomenology. I explicitly engage with the tensions between power and experience in the articulation of clinical and personal understandings and mobilizations of “body image,” and consider the points of conflict and alignment between poststructural and phenomenological inquiry in the context of the effects of surgical intervention. This chapter closes with a brief mediation on the disconcerting slippage between health and aesthetics in the context of both elective breast surgery as a practice and the narratives of body image that surround these procedures.

Chapter 6 concludes the dissertation by detailing the primary empirical and theoretical findings of the project as well as considering the implications of this project. It focuses on the project’s contributions to thinking through how elective breast surgery intersects not only with experiences and constructions of the body and embodiment but also with the conceptual and material collapse of health and aesthetics. This final chapter also considers how this project contributes to thinking about the operation of power on the body and for the phenomenological articulation of the lived body, and more broadly considers what these findings mean for poststructuralist thought, phenomenological inquiry, and feminist thinking on the body, respectively. As a whole, this project elucidates and works to make sense of the tensions that the routinization of surgery institutes between inside and outside, subjectivity and objectivity, private and public, reconstructive and aesthetic, and phenomenological and poststructural inquiry.

CHAPTER 2: ALIGNING PHENOMENOLOGY AND POSTSTRUCTURALISM TOWARDS THEORIZING BODY IMAGE AND ELECTIVE BREAST SURGERY

Introduction

The purpose of this chapter is to establish the theoretical frameworks and review the relevant literature and concepts that inform this dissertation project. In particular, this chapter considers Foucaultian poststructuralism and Merleau-Pontian phenomenology, both independently and at their respective points of intersection with feminist theory and each other. Drawing on extant phenomenological, poststructuralist and feminist literatures, this chapter articulates how poststructuralism and phenomenology can be brought together in a productive dialogue, and, given the feminist concerns of this project, it does this by emphasizing how these two theoretical orientations articulate and position the body. In addition, because this dissertation draws on and applies the theoretical insights of poststructuralism and phenomenology in its consideration of women's experiences of elective breast surgery in the context of Western biomedicine, it is important to examine how phenomenology, poststructuralism and feminist theory have critiqued biomedical discourse and practice both historically and in the contemporary moment, and how feminist theory has, throughout, been integral to the trajectory of this critique.

The first part of this chapter engages with phenomenology, focusing first on Merleau-Ponty's conceptualization of the subject by emphasizing his articulation of bodily intentionality and body image/schema. Then, I examine phenomenological conceptualizations of body image/schema to emphasize how, from a phenomenological and feminist phenomenological perspective, body image/schema is an integral aspect of human experience. From there, I consider the contributions of feminist theory to phenomenology more broadly, specifically

considering feminist phenomenological engagements with embodiment, body practices, and body experience. The last section in this part of the chapter considers the overall phenomenological critiques of Western biomedical health and health care to demonstrate the contributions that phenomenology can make to our understanding of health and illness at the level of experience.

The second part of this chapter takes up poststructuralist thought, focusing on Foucault's conceptualization of the subject as demonstrated in his articulations of bodily discipline and normalization. From there, I articulate the mainstream conceptualization of body image and then position this notion of body image as a product of the Psy-complex. I then take up feminist poststructuralist engagements with the body, embodiment, and body practices but, given the far-reaching nature of this research, focus on those that emphasize a critique of health and health care as investments in the discipline of female bodies. I then consider Foucault's personal and intellectual relationship with phenomenology, in terms of his rejection of the phenomenological approach and, in turn, the resulting assertion by many scholars that phenomenology and poststructuralism are incompatible. I conclude this chapter by drawing on recent theoretical explorations and case studies to show that phenomenology and poststructuralism can be effectively brought together in a compatible and productive theoretical framework.

Intentionality and Materiality: Merleau-Ponty and the Constituting Subject of Phenomenology

Phenomenology has had a long and sustained interest in understanding and exploring how we experience the body in and of itself and in the world (e.g., de Beauvoir 2011; Carman 1999; Csordas 1999; Fielding, 1996; Kruks 2001; Levin 2008; Oksala 2004, 2016; Sheets-Johnstone 2005; Stoller 2009; Weiss 1999; Young 2005). As is well-known, this interest in the

body is primarily inspired by the work of Merleau-Ponty, whose phenomenology centers the body-as-such. Merleau-Ponty's work shows that mind and body are not opposed but interconnected, that the mind is always embodied, and that the body is central to human consciousness. Merleau-Ponty (2013) affirmed the unification of mind and body by emphasizing how the body comes to symbolize our existence and our subjectivity. He asked: What is a body? How do I experience the world through my body? What is the nature of embodiment? What can my body do? How does my body interact with the bodies of others and with the things in the world? In particular, Merleau-Ponty (2013; 1968) was concerned with the relationship of the body to external perception in a way that did not necessarily privilege the structure and position of consciousness.

The objective of phenomenology is to provide "a direct description of our experience as it is" (Merleau-Ponty 2013, vii). Phenomenology apprehends lived experience *prior* to objectivity: it is marked by "a return to the world of actual experience, which is prior to the objective world" and, relatedly, a commitment to "rediscover phenomena" (Merleau-Ponty 2013, 66). Phenomenology, then, is a commitment to the description rather than explanation of experience and it is distinct from and opposed to intellectual and empirical approaches. Merleau-Ponty (2013) specifically positions phenomenology as a radical break from traditional scientific (including traditional psychological) and analytic philosophical approaches (specifically Cartesian and Kantian approaches) to the understanding of lived experience. He problematizes empiricism and intellectualism, opposing them on the grounds that they take the body and the world as mere objects to be exploited by consciousness in its constitution and possession of the world (Merleau-Ponty 2013). For example, because Cartesian and Kantian approaches rely on a dualism that detaches the subject from consciousness, consciousness then becomes the only

means by which the world or anything in it can exist. Merleau-Ponty (2013) disagrees with and rejects this dualistic thinking, arguing that it reduces the body to an exterior with no interior. Similarly, he critiques traditional psychology for perpetuating this dualism, and for positioning the body as a “mechanical” thing with “no inner life,” the experience of which can only be represented as psychic fact (Merleau-Ponty 2013, 108-109). He attends to and re-centres the body for the purposes of unification: his intention is to reunite consciousness with the body from which it has become alienated, to demonstrate that the body is not merely a physical entity or object, and, perhaps most importantly, to affirm that the body is essential to and for being-in-the-world.

This is Merleau-Ponty’s corrective to objectivist articulations of lived experience that privilege consciousness at the expense of attention to and representation of embodied experience. He demonstrates that the body is not merely a passive object that houses the consciousness that then creates and lives in the world. It is not, he writes, “an object for an ‘I-think’” (Merleau-Ponty 2013, 177). In fact, the body is an active and spontaneous “I-can” that is imbued with intentionality, the capacity to endow objects and experiences with sense. Merleau-Ponty counteracts the Cartesian passivity of the body by affirming that it is active and integral to the constitution of subjectivity. Interlinked with the assertion of the body’s intentionality is the recognition that it is through the body, and not solely consciousness, that I apprehend the world and communicate with it. Further, the world is “co-given,” or simultaneous with lived experience. The world as a unity is not, as objectivist traditions claim, constituted by knowledge in an act of identification; rather, the world is lived as “ready-made or already there” (Merleau-Ponty 2013, xix). In other words, the creation of the world is not the result of an act of

consciousness positing or affirming its knowledge of the world and what it is; instead, self and world are co-constituted via a symbiotic relationship.

This return to the body is an essential component of phenomenological inquiry, for it demonstrates the unification of embodiment and consciousness, and ultimately reveals that embodiment is inextricable from my apprehension and thus my lived experience of the world. My experience of my body is my experience of my body in the world. Yet, this shift does more than simply repair a binary by affirming that I exist in the world by virtue of my body; it reveals that my *being* is entirely bound up in and with my embodied experience of the world. Merleau-Ponty (2013) cites Gabriel Marcel, who writes, “I am my body” (231). The body is thus the “primordial” or originary mode of interaction, enmeshment, involvement, perception, and experience of the world: my body is my primary means of engaging with the world, and my consciousness is always already an embodied consciousness. For Merleau-Ponty, it is through the body that existence is realized and that I come into being-in-the-world.

Merleau-Ponty (2013) repositions the body as subject and thus as integral to the formation of human experience and subjectivity. Importantly, he acknowledges the possibility that the body can take up the status of an object, but he does not concede that object status marks the entirety of the body’s nature. He offers that the body is an object because it contains parts distinct from the whole, and because its parts contain the possibility of the movement and eventual disappearance from the visual field. Like any object, the body is perceived by the self and it is in this respect that it can comprise object status. But, unlike objects that are entirely outside of the body, the body can never be perceived by the self in its entirety; that is, the self can never see fully the body from the vantage point outside of the body. Merleau-Ponty is careful to avoid an account of the body that reduces it to being simply one object amongst other objects.

Instead, the body is reconceptualized as distinct from other objects, and functions as a “nexus” of lived meanings (Merleau-Ponty 2013, 175): it is the connection point for the experience of phenomena and the meaning(s) of the experience of phenomena.

Body Image/Schema in Phenomenology

Merleau-Ponty’s work determines, in part, the position and significance of the body in and to perception, and explains how embodiment structures consciousness. Merleau-Ponty established that the body is irreducible to an assemblage of organs in space or to a mental representation of said assemblage. In *Phenomenology of Perception*, he identifies the body as an “indivisible possession” that encompasses mind *and* body and reflects this unification (Merleau-Ponty 2013, 100). Merleau-Ponty’s conceptualization of the body is one that is neither purely a physical system nor purely a psychic system. Accordingly, then, Merleau-Ponty’s (2013) articulation of the body schema is premised upon his rendering and positing of the body as an ambiguous mode of existence wherein the body is neither purely object nor purely consciousness but rather a point of view upon the world that is determined by the synthesis between mechanistic and conscious projection. The *schéma corporel* (body schema),⁸ as Merleau-Ponty (2013) interprets it, is explicitly posited as an “ambiguous” notion that reflects the prereflective or primordial awareness humans have of our embodied experience (101).⁹ The body schema is not a form, a representation (or image), or an indication of our body’s position in space. While

⁸ There has been much debate, partially in light of problems of translation, as to whether Merleau-Ponty was referring to a (physiological) body schema or a (representational) body image in the *Phenomenology* (Landes 2013; Taipale 2014). Many scholars, working from the 1962 translation that was, until recently, the only available English translation, understand Merleau-Ponty to be using the terms “body schema” and “body image” relatively interchangeably and some have done the same in their own work (Fielding 1996; Levin 2008; Weiss 1999). As I will address, much theoretical energy has been given to this question of the difference between body image and body schema, with some scholars arguing for separate conceptualizations and usages for these two concepts given their contentious history (e.g., Gallagher 2005; Gallagher and Zahavi 2013; Taipale 2014).

⁹ In discussion of Merleau-Ponty’s phenomenology, I will use the term “body schema” not only to retain consistency with the translations of the *Phenomenology* but also because, in light of the work by Carman (1999), Fielding (1996), Levin (2008), “body schema” is the term that best aligns with the openness of embodied expression, capacity, and possibility that I explore in this project.

the body schema is, importantly, indicative of the way that we come to habitually understand the position of our limbs in space, it is not reducible simply to the body's situatedness in space (Merleau-Ponty 2013, 2007b). On the contrary, the body schema "gives us at every moment a global, practical and implicit notion of the relation between our body and things, of our hold on them [...] Our body is not in space like things; it inhabits or haunts space" (Merleau-Ponty 2007a, 285). The body schema, then, is more than an awareness of the body in space—it is our manner of *expressing* or animating the body in space, and it is the way we establish and make sense of the *contact* between the self and the world (Merleau-Ponty 2013, 2007b). "The consciousness I have of my body," he writes, "is not the consciousness of an isolated mass [...], it is the perception of my body's position in relation to the vertical, the horizontal, and certain other axes of important coordinates of the milieu in which it finds itself" (Merleau-Ponty 2007b, 147). In Merleau-Ponty's phenomenology, the body schema is connected with the analysis of "the exceptional relationship between the subject, its body and its world" (Merleau-Ponty 2007a, 284).

Merleau-Ponty's conception of body image/schema is directly informed by the work of the German psychologist and neurologist Paul Schilder who developed the concept of the "body image" in the phenomenological sense. In *Image and Appearance of the Human Body*, first published in 1935, Schilder posits his articulation of the "body image."¹⁰ Informed theoretically by early neurological studies (Head and Holmes 1911; Head 1926), as well as Freudian psychoanalysis, Schilder's conceptualization of the body schema is a multifaceted and ever-

¹⁰ Schilder himself translated *Image* from German into English and, in so doing, translated *Körperschema* to "body image" (rather than the more literal "body schema"). The reason for this remains unknown. In fact, only a handful of instances of "body schema" occur in the text. Despite this, I will use "body schema" when writing phenomenologically. I will retain Schilder's use when directly quoting from his text. To maintain consistency with the other writings I shall cite, I will not hyphenate body image, even though Schilder himself does hyphenate the term.

changing model of a body engaged in continuous activity. Yet, Schilder's work (and Merleau-Ponty's) elaborates upon the model established by Head (1926) by moving beyond a postural and schematic model towards a model that also considers the physical, social and imaginative aspects of bodily experience. For Schilder, body schema is a concurrent function of physicality and sociology, and of mental representation and bodily perception (Schilder 1950). *Image* comprises Schilder's engagements with case studies of both his own and others' patients. These studies include cases of neurological and psychological "disorders," "conditions," injuries, and/or "abnormalities."

Schilder (1950) was concerned with and motivated by the ways in which people come to know and experience their bodies on the inside and outside and, subsequently, to understand how that knowledge intersects with the social experience of our own body and the bodies of others. The body schema is the manner in which one makes sense of and understands their status as corporeal and embodied. Schilder (1950) understood the body as a unit *and* as an entity (object) in that he refuses the distinction between *leib* (lived body) and *korper* (object body) (283). Our knowledge of the body, he says, comes to us from several sources, including: the sensory and motor components or functions of the body, awareness of the correct location of our limbs (the postural model of the body) the relationship between the limbs, the psyche, sensuality, personality and our relations with others (Schilder 1950). It is also informed by our clothing and the technologies and tools that we use (Schilder 1950, 202-203). The body schema is the product of knowledge that we gain not only from our own bodies but also from the objects, other bodies and space in the world around us. The body schema is directly bound up with lived experience and intersubjectivity (Schilder 1950; Weiss 1999). This "knowledge" ranges from vague to clear

and from partial to complete (and back). The product of this knowledge coalesces into an image of the body that develops alongside us, across experience, and over time.

As in the psychological articulation of the body image, which will be described later in this chapter, the body schema risks disruption or dissolution. For Schilder (1950), this disruption occurs if we neglect to continuously maintain the body schema.¹¹ Schilder (1950) writes that “we are dealing with a spreading of the body schema into the world [and] a spreading of the body into the world...The organization of the body image is a very flexible one” (188). Still, the tendency toward destruction or dissolution of the body schema is not entirely problematic for Schilder; instead, it signals the opportunity for a renewal of the body schema. While the body schema may be disturbed by, for instance, lesions that “impair” or perhaps change our tactile or optic sensations, such disturbances are not correlated with the creation of a deficiency in the body schema. Instead, shifts to the body schema provoked by body change are imbued with the possibility for creating the body schema anew. Schilder’s work also demonstrates a model of the body predicated upon the unification of mind and body. Schilder (1950) recognizes, drawing on Freud, that because there is a “deep community between psychic life and organic function” (33), there can be “no *psychic* processes in which no *brain* mechanism is involved” (1950, 28, emphasis added). The interconnectedness and inseparability between mind and body that Schilder (1950) identifies is linked with his formulation of how we construct our body schema: “It is not the case that the schema of the body has two different parts, the one optic and the other tactile. [Our] experience of our own body is based upon optic and upon tactile impressions” (38).

In contemporary phenomenological literature, there is much contention over what the “body schema” actually is, particularly in terms of its relation to the concept of “body image”

¹¹ At the same time, it is always in a state of dissolution because we lose parts of ourselves to the world (excrement, hair) and we project parts of ourselves into the world (voice, language).

(Carman 1999; Gallagher and Zahavi 2013; Gallagher 2005; Hanley 2005; Mishara 2005; Sheets-Johnstone 2005; Taipale 2014). Despite, or perhaps because of, the long history of the idea of the body image or schema in Western thought, the concept has been plagued with tension and conflict over its meaning and use. Shaun Gallagher is best known for articulating the “difference” between the body schema and the body image. For Gallagher (2005), the body schema is the neurological organization of the body that makes it possible to carry out physical tasks, while the body image is one’s psychological, conceptual, and perceptual experience of the body. Gallagher (2005) maintains this distinction, but he allows for overlap, writing that the “body image and body schema refer to two different but closely related systems [that] interact and are highly coordinated in the context of intentional action” (24). Despite this intimacy and coordination, “a body schema is not reducible to a perception of the body; it is never equivalent to a body image” (Gallagher 2005, 27). Gallagher’s formulation has gained traction and been used extensively throughout the past decade. Scholars in agreement with Gallagher, and who support a distinction between body image and body schema, suggest that the body image is a cognitive experience, while the body schema is not available to cognition (Mishara 2005; Slatman 2007, 2015; Sheets-Johnstone 2005; Taipale 2014).

Feminist Phenomenological Theories of the Body

Feminist theorizing on the body and embodiment relates to Merleau-Ponty’s phenomenology in a manner similar to how it relates to the work of Foucault. Specifically, feminist theorists critique Merleau-Ponty for his neglect of the gendered body, yet acknowledge that his work is nonetheless useful for feminists. Elizabeth Grosz (1994), Gail Weiss (1999) and Iris Young (2005) follow Luce Irigaray’s (1993) critique of the masculinist bias in Merleau-Ponty’s work. Irigaray’s (1993) interrogation of Merleau-Ponty prompted feminist thinkers to

acknowledge and agree that his account of the body as a ground for all perception applies to human experience in a general way, but never recognizes the primary impact that axes of difference, such as sex, gender, race, ability, and class, have on how and what we experience.

There is, despite these critiques, much in phenomenology that is of use for feminist thinkers. In particular, phenomenology is considered to be a philosophy of experience and therefore intersects with feminist work that often draws on the concept of experience to demonstrate the fact that women have different experiences than men (Stoller 2009). “Because phenomenology posits experience as situated and based in the body,” writes Silvia Stoller (2009), “it opens up the possibility for a phenomenological description of different gender experiences, including...the different experiences among women” (728). Phenomenology’s attention to experience also intersects with feminist political efforts to account for and document women’s experiences as a part of consciousness-raising efforts (Kruks 2001). Grosz (1994) argues that, insofar as Merleau-Ponty’s work emphasizes lived experience, the body-subject, the limitations of binary oppositions, and the production of dominant knowledges, it too resonates with early feminist theory of and activism around the body. Weiss (1999) points out that phenomenology, like feminism, aims to uncover and articulate that which is indeterminate.

Iris Young was one of the first feminist philosophers to engage with the phenomenology of sex and gender in a sustained way. Her studies of female body experience consider menstruation, feminine movement, pregnancy, and women’s fashion. In her essay on female “breasted experience,” Young (2005) considers the significance of the female breasts to female body experience in the Western industrial, patriarchal context. She argues that breasts are the “primary things” in the “total scheme of objectification,” for they function as the signal and sign of female sexuality and the tangible signifier of womanliness in the clothed public sphere (77,

82). Breasts are valued as objects, are measured for size and shape, and are evaluated for their adherence to ideas of what constitutes proper placement, roundness, and hardness. She suggests that the ongoing public and socio-cultural evaluation of women's breasts impacts the way that women carry themselves in the world: women who are bothered by their breasts and the attention the breasts generate may develop a posture that reduces their noticeability, whereas women who are pleased with their breasts may emphasize their visibility (Young 2005). In this way, the breasts are an important component of body self-image. Young (2005) also finds that Western patriarchal cultures position the breasts as an object for male attention and pleasure, which, in turn, denies women the ownership of their breasts. A woman's breasts "belong to others—her husband, her lover, her baby" (Young 2005, 80). As a result, women living in Western industrial societies are, she says, rarely neutral in their relationship to their breasts.

Against the usurping of the breasts by patriarchy, Young (2005) argues that women can recover and imagine a "woman-centered experience of breasts" (80). She argues that the breasts can be lived as constitutive of a specifically female desire once we acknowledge that every woman "deserves her own irreducible pleasures" (90) and conceptualizes the breasts as livable in ways that emphasize female pleasure over objectification. Young (2005) proposes that the refusal to wear a bra is one such way that women can claim ownership of their breasts. The social obligation to wear a bra denies, through restriction, the fleshy reality of the breasts; in unbinding the breasts, women can reconnect with the felt sense of and sensation given by their breasts. "Unbound breasts," she writes, "show their fluid and changing shape; they do not remain the firm and stable objects that phallocratic fetishism desires [and they] make a mockery of the ideal of a 'perfect' breast" (Young 2005, 83). Young also suggests that women can seek erotic pleasure in breastfeeding as a way to deobjectify and take pleasure in the breasts and also as a

way to destabilize the strict border between the reproductive and erotic body. In these ways, women's breasts can be (re)imagined as a source of "bodily habitus" and as a source of sexual pleasure and bodily pride.¹²

Feminist phenomenology has since moved beyond early critiques of phenomenology's ignorance of difference, and now intersects Merleau-Ponty's thought with a broad range of aspects of corporeality and embodied life in order to introduce differences into phenomenological thinking in a sustained way. Helen Fielding (1998) and Gail Weiss (1999), respectively, call for an embodied ethics that, through bodily identification, can determine the needs and desires of the other. Judith Butler (1997) emphasizes the fact that Merleau-Ponty's phenomenology reveals that sexuality is not an instinct or drive but is instead a mode of existence intertwined with the entirety of human life. Butler's work opened up space for additional considerations of the intersections between phenomenology and sexuality. Sarah Ahmed (2006), for instance, takes a queer phenomenological approach to sexual orientation and rethinks how the fact that the habitual body is directed toward certain objects and not others shapes bodily and social space. Also, Gayle Salamon (2010) draws on phenomenology to demonstrate that trans bodies express a mode of embodiment that is irreducible to their materiality. Therefore, one aspect of phenomenology that has received much feminist attention has been the notion of bodily experience, and feminists have placed particular phenomenological emphasis on the intersection between gender and sex in bodily experience. Feminists who appropriate Merleau-Ponty in their engagement with phenomenology consider "the basic modalities or structures of female embodiment that are typical of feminine existence," with the broader aim of describing "the eidetic structures of the living body" (Oksala 2016, 99).

¹² Weiss (1999) engages in a comprehensive elucidation and critique of each of Young's essays. For additional critique of Young's position on female body experience and female motility, see Preston (1996) and Chisholm (2008).

Feminist Phenomenology and Body Image/Schema

Given feminism's longstanding political and philosophical interest in the body, feminist phenomenologists have, understandably, also been concerned with the way that the body image has been conceptualized and used in phenomenological inquiry. As Weiss (1999) writes, "it is feminist theorists who have taken up the task of articulating the social and bodily forces that both constrain and enable the development of body image" (38). This concern has been marked by feminist phenomenology's aforementioned interest in extending phenomenology to acknowledge and account for corporeal difference, both in and of itself and in terms of the social and lived effects of corporeal difference. Many feminist phenomenologists have taken up the concept of the body image and/or schema, but have focused on identifying and addressing its limitations, rather than on applying it to different aspects of lived experience. Elizabeth Grosz (1994) and Gail Weiss (1999) start from the position that phenomenological and psychological accounts of body image or schema neglect to acknowledge the ways in which bodies are marked by gender, race, class, ability, sexuality, and illness, among other markers of identity. Extant representations of the body schema or image are informed by a body that is largely anonymous (Weiss 1999) and therefore grounded by a masculinist norm (Grosz 1994). In turn, theorizations of body schema do not understand, as both Irigaray (1983) and Young (2005) identified, the specific and material experiences of "other" bodies.

Feminist phenomenologists thus work to expand the notion of body image/schema to include bodies that are marked as distinct by socio-cultural norms and patterns (Malmqvist and Zeiler 2010). These rearticulations of the body image can be situated within the broader feminist project that, in decades past, aimed to challenge and direct phenomenological inquiry to include the experiences of bodies marked by difference. These critiques and revisions are crucial because

they refuse the immaterial description of the body-as-*such* in favour of the material body-as-*lived* (Moi 1999; Weiss 1999). Grosz's (1994) writing on the body image traces the neurological and psychological work on the body image from Greek antiquity to the then-present. Grosz's work is significant because it presents a comprehensive survey of the history of the concept of body image, which identifies that the idea of body image emerged as early as Aristotle's idea of the *pneuma* (spirit or soul), maintained a presence in the early modern era in the philosophical work of Descartes and the medical writings and studies of Ambroise Paré and Hughlings Jackson, and continued to be relevant in early 20th century studies like those of Head, Schilder and Merleau-Ponty. Grosz's (1994) survey is useful because it offers up the content of historical writing on body image, and because it gives an indication of the conceptual links between Schilder and Merleau-Ponty. She does express one crucial reservation about the masculinist norm that informs this work: "Schilder, like virtually all the theorists of the body image, does not specify that male experience is taken as the norm and women's experience is discussed only insofar as it deviates from or compares to this referential framework" (Grosz 1994, 82). Beyond critiquing the androcentrism upon which it is based, Grosz (1994) offers little insight into the body image as a concept and/or its usefulness for feminist phenomenology.

Weiss (1999), by contrast, critiques germinal theories of body image/schema but also extends the reach of body image/schema to emphasize the gendered, sexed, and raced aspects of lived experience that impact our body image/schema. Through close readings of Schilder, Merleau-Ponty, de Beauvoir and Young, she establishes that the phenomenological body image is a fluid and multiple form that is often resistant to cultural forces. Crucially, Weiss (1999) challenges the conceptualization of "the body" and "the body image" in the singular, suggesting that because bodies are always already engaged with the world, they are not isolated in their

activity and thus incapable of being rendered as the “discrete phenomena” that the definite article implies (1). Drawing on extant theory as well as case studies of lived experiences such as mothering and anorexia nervosa, Weiss (1999) establishes that there is no singular “body” or “body image.” Our body *images* are not discrete but are instead “co-present,” continuously plural, and constantly changing (Weiss 1999, 2, 17). The definite and continuous (re)construction and deconstruction that the body image undergoes—occurring in response to internal physical changes, responses to other bodies, and responses to our situation—reveal that a mode of *shifting* body images is actually the manner in which we live the world (Weiss 1999).

Weiss (1999) thus argues that there is a multiplicity of body images contained within any given individual, and this multiplicity is felt by the individual as a non-dualistic sense of corporeal agency—neither purely immanence nor purely transcendence. She argues that transcendence and immanence are always co-present in any body. Her formulation opposes theorizations of the body that, in taking up the distinction between transcendence and immanence, privilege transcendence by positioning it as freedom, motivation, and intentional activity (Weiss 1999). Young’s essays, Weiss (1999) suggests, understand embodiment in a way that perpetuates immanence as inferior to transcendence, despite their insight into and awareness of a tension between immanence and transcendence in woman’s situation. The consequence of this, Weiss (1999) argues, is that it perpetuates the depreciation of the “immanent” body and so reinforces rather than contests the Cartesian framework. Working against this perpetuation of Cartesianism, Weiss calls for theorizations of body images that avoid further denigration of the body. However, feminist critiques of the masculinism of phenomenology in particular and in philosophy more generally are at risk of perpetuating this bias when the body is affirmed as immanence and the mind as transcendence. The resolution to this dilemma, for Weiss, is a

resituating of body images in a frame of “embodiment as intercorporeality.” To explicate this, she develops the notion of the “body image ideal,” where our construction of an ideal image of our bodies is a fundamental and material function of the psychoanalytic notion of the ego-ideal. The body image ideal is not necessarily that which one wants to emulate or reformulate their own body image to be more like; instead the body image ideal is an image that functions for the purposes of comparison and evaluation. Because the experience of being embodied is never private but instead constantly mediated by our interactions with human and non-human bodies, our body images are constantly interfacing with and informed by our social conditions and communicative experiences.

Jenny Slatman’s phenomenological writing on the body image focuses on our experience or felt sense of our bodies in space. Slatman (2014) maintains a distinction between body image and body schema, positioning the body schema as “the preconscious system of motoric and sensory abilities” and the body image as “the conscious system of perceptions, postures, and beliefs regarding our own body” (66). Slatman describes the body schema as a “felt unity” because we know the position and location of each part of the body at any given time. Slatman (2014) maintains that this unity is made possible by our ability to consider the body as a thing, or because “being a subject is inscribed in being an object” (20, 26; Slatman and Widdershoven 2015). Slatman (2007, 2015) positions medical imaging technology as one site wherein this simultaneous subject-object status manifests itself. Medical imaging technology, she finds, is one conduit through which our body image is mediated by our interaction with that which is outside of ourselves. Our experiences with technologies of the “inner” body, like CT scan and MRI are useful in rethinking the idea of “body image,” for they produce literal body images (Slatman 2007). Such technologies, which objectify and visualize what belongs to our “subjective and

invisible experience” produce new images of the body that in turn change our experience of the body (Slatman 2007, 187). Slatman (2007) suggests, through a phenomenological engagement with Mona Hatoum’s video-installation *Corps Étranger*, that the visualization of the inner body allow us to think of and understand the body image in terms of an “affective image” rather than a “visual” image (188). When we see images of ourselves that are produced by medical imaging technology, they feel unfamiliar; we do not and cannot recognize the images the technology produces as belonging to our bodies (Slatman 2007). Medical imaging technology disrupts our understanding of the body as our “own” body and in this way provokes a disruption in our body image. Because the endoscopic camera or MRI “turns the interior into a surface,” it produces for the subject an image that is not recognizable as part of our own body but is instead recognizable as our own strangeness, for we do not move this body or attempt to appropriate or incorporate images of it into our body image (Slatman 2007, 196). The body’s “ownness,” Slatman (2007) concludes, “is conditioned by a strangeness or alterity that cannot be captured by reflection” (201). Medical imaging technology simultaneously shows us our “me-ness” and our strangeness, and, in this way, expands the understanding of body image to include that which is part of the body but not the body as an intact and recognizable entity or possession. Slatman’s (2007, 2015) analyses show that the body image is not always composed of a *comprehensive* knowledge of the body or a knowledge of the body that accounts for the full depth of its interiority.

Feminist phenomenological contributions to the study of body schema have thus offered theoretical explications as well as experiential and first-hand data to support their studies about the nature and reality of the body schema. These contributions have attended specifically to the gendered nature of body schema, revealing the manner in which the perceptual and motor aspects of the body schema are influenced by social norms and embodied difference. The

feminist understanding of female body experience has been crucial to demonstrating the limitations of phenomenology and to including feminist concerns within the field; however, feminist phenomenological studies that take a sustained interest in the body schema or body image are quite limited in number. Luna Dolezal (2015) recently examined the impact of cosmetic surgery on body image in the context of what she calls “body shame,” while Cressida Heyes’s (2009) analysis of body dysmorphic disorder (BDD) suggests that body image is leveraged as a justification for cosmetic surgical intervention. In contrast, there is a plethora of non-phenomenological feminist studies of body image that focus on body (dis)satisfaction (e.g., Crook 1991; Engeln-Maddox 2005; Grabe et al. 2008; Grogan 2008; Markula 2001; Murnen and Smolak 2009; Slevec and Tiggemann 2010; Turner et al. 1997). Chapter 4 of this dissertation responds to this work by undertaking a phenomenological investigation that examines how women who have experienced breast augmentation or reduction articulate their body image/schema in terms of embodied experience and bodily possibility.

Phenomenological Critiques of Biomedicine

Given that phenomenology has had a longstanding concern with the body and the significance of the body for subjectivity and human experience, it makes sense that phenomenologically informed thinkers are concerned with health, health care, and medical practice. Phenomenological inquiries into biomedicine are concerned with the ways that clinical practice functions as an instrument of power that regulates the body at the expense of the patient’s subjective experience and well-being. Phenomenologists work to uncover patient experience and its meanings in a context that elides and/or erases it. Such work develops practical recommendations for how phenomenology can help to recover patient experience(s) (Carel 2011), while other studies have considered the ways in which biomedicine has, to the

detriment of patients, been grounded by a view of the body as an object (Shildrick 2002, 2008; Leder 1984, 1990; Toombs 1992). These investigations consider how the biomedical context intersects with and neglects to comprehensively understand patients' lived encounter(s) with illness. Phenomenological inquiry has generated numerous critical studies of biomedicine's treatment of human health and illness as a problem of the body alone, and many health care practitioners have drawn on phenomenology to adequately account for the patient perspective.

The Cartesian tendency to separate mind from body and to privilege the "rational" mind at the expense of the "distractive" body has been the grounding framework for the development of Western biomedicine. It is well-established that this frame has had negative consequences for how patients and bodies are consequently perceived and treated. A fundamental certainty of Western biomedicine is its view that "the body can be remolded [...] without consequences to the embodied subject" (Shildrick 2008, 38) as well as "tested experimentally," "blueprinted," and made "susceptible to mechanical intervention" (Leder 1984, 30). Western medicine has viewed the unwell or deficient body as a machine to be fixed (Leder 1984; Shildrick 2008). Within this model, it is the dead body, not the lived body, that grounds medical thought and practice, particularly because medical students, for a long time, learned primarily on cadavers (Leder 1984; 1990). The phenomenological critique of biomedicine contests the fact that biomedicine is purely interested in the physiological causes of and factors for illness and disease. From this view, the lived body—"wherein subjectivity is always corporeally expressed" (Leder 1984, 39; Moi 1999)—disrupts an understanding of physiological events and is thus often discounted in favour of physiological explanations (Greenfield 2011; Thomas 2000; Toombs 1992; Zaner 1988). The movements of the lived body, which is the body the patient presents in the clinical encounter, always respond to a perceived world and a desired future, are born of

meaning, and are not just mechanical impingements. The dead body is therefore preferred because it is, by contrast, a self-contained, sheerly material and predictable *thing* that can be worked on and manipulated as needed. The non-responsive object-body is the dominant body of biomedicine, for it does not react to and, therefore, does not interfere with treatment (Leder 1990).¹³ Leder's (1990, 1984) interpretation of the body in medicine is reflected in more recent thinking that emphasizes the biomedical view of bodies as technical systems and argues that, from this perspective, there is no depth that medicine cannot uncover—only more surfaces (Fielding 1999; Slatman 2007; Slatman and Widdershoven 2015). Given this model, contemporary biomedical practice typically neglects to consider the patient as a legitimate partner in the clinical encounter, and many patients experience their treatment as “reductionist or dehumanizing” (Leder 1984, 36).

Recent phenomenological inquiries have explored the effects and consequences of biomedical health care and practice on patient experience and medical treatment. Havi Carel and Ian James Kidd (2014) argue that the testimonies and accounts given by ill people are often rendered epistemically invalid in the biomedical context because these accounts are not expressed in the terms of biomedical discourse. Sara Shabot (2016) engages feminist phenomenology in recalling her own experience of obstetric violence during childbirth, arguing that medical intervention in childbirth forecloses the possibility of labouring authentically. Other studies have used phenomenology to better understand health conditions and to make recommendations for improved health care. Sandra Thomas's (2000) phenomenological study of people who live with chronic pain finds that chronic pain sufferers express a “fragile trust of

¹³ Importantly, as Leder (1984) points out, the patient can also come to regard their body in the clinical/objectified mode. Painful and ill bodies often become an alien presence, and, in cases of troubling body parts, the unity of the lived body disintegrates and the body instead is revealed as a series of “semi-autonomous biological processes” (Leder 1984, 33; see also Slatman 2014, Slatman and Widdershoven 2015, and Svenaeus 2015).

physicians”: they seek out health care professionals towards the goal of pain relief but, at the same time, they express that physicians do not listen to them (692). Thomas’s (2000) work indicates the relevance of a phenomenological approach to chronic pain, for the very nature of chronic pain—oftentimes immeasurable and untreatable using “objective” techniques and/or imaging technologies—means that patients’ descriptions are the only way that health care practitioners can understand patients’ subjective experience(s) with and sensations of pain.

The distinction that phenomenology makes between the immediate, pre-theoretical world of everyday life and the scientific account of experience has been cited by Toombs (1992, 2001) as significant in helping to make sense of the difference between one’s immediate experience of illness and the conceptualization of illness as a disease state. A phenomenological perspective can uncover the dehumanizing aspects of biomedical practice and, subsequently, it can improve patient experience and treatment (Connolly 2001; Greenfield 2011; Kaufman 1988; Leder 1990; Thomas 2000; Toombs 1992). Phenomenology opens a space for making sense of first-person, first-hand, and insider accounts of illness. Second, it can illuminate the aforementioned conflict between traditional biomedical approaches to the body and lived body approaches to the body. Third, it can recover the lived body of the person receiving care as well as the person themselves. Overall, the validation of the lived body can reorient medicine towards better quality care (Leder 1984). Overall, the phenomenological perspective is distinct from and useful to the biomedical approach because it starts from the point that the body is not merely a biological organism but also “a person’s embodied point of view on the world” (Svenaeus 2015, 110).

One goal of phenomenological studies of medicine, then, has been to agitate the biomedical model so that it accounts for lived bodies and, with this recognition, includes patient narratives. In an early inquiry into the value of phenomenology for studies of illness and health,

Sharon R. Kaufman (1988) writes that “employing the phenomenological perspective to explore the subject of boundaries in medicine allows us to see the ways in which humanity is limited and compromised by illness and to identify how and the extent to which medical knowledge, authority and responsibility both respond to and influence that experience” (340).

Phenomenology has had a significant impact on research and practice in nursing. In the 1980s, nursing researchers began to recognize the limits of measurement, objectivity, and statistics and started to take up phenomenology as “a research method that could provide understanding of the person’s reality and experience, one that valued individuals and the nurse-patient relationship [...] and one which embraced a holistic approach to the person” (van der Zalm and Bergum 2000, 211-212). Brigitte S. Cypress’s (2011) phenomenological study of the ICU traced the experiences of patients, family members, and nurses, and found that patients, nurses, and patients’ families formed a “unit” that, together, offered psychological support and physical care. Cypress (2011) concludes that, given their place in the “unit,” family members should be permitted in the ICU during invasive procedures and/or resuscitation, so long as their presence can be accommodated by hospital or institutional procedures. Researchers and health care professionals more broadly speaking have also drawn on phenomenological methods to study a range of health care issues, including chronic pain (Osborn and Smith 2015; Smith and Osborn 2007), breast cancer (Boehmke and Dickinson 2005; Park and Yi 2009), and ill mental health (Fuchs 2005; Fuchs and Schlimme 2009; Meynen 2011; Sass and Parnias 2007).¹⁴ A phenomenological analysis can also expand studies of illness experience, broadening out from first-hand accounts to an articulation of how the features of illness resonate in the lifeworld (Carel 2008; Fisher 2014). In light of these phenomenological critiques of the objectification of

¹⁴ For a detailed articulation of how phenomenology has been taken up to think through and understand patient experiences of illness, see Havi Carel’s (2011) piece, “Phenomenology and its Application in Medicine.”

patients and the biomedical invalidation of the socio-cultural conditions of existence and experience, feminist-phenomenological engagements with biomedicine that give specific attention to female body experiences have increased over the past fifteen years (e.g., Connolly 2001; de Boer, van der Hulst and Slatman 2015; Fisher 2014; Slatman 2012; Zeiler and Folkmarson Käll 2014). These objectives inform this dissertation project, which is in itself an attempt to describe bodies as they are “intertwined with the world and with others” and not bodies in their “objective being” (Fielding 1999). This project follows such analyses, continuing to extend the reach of feminist phenomenology by considering the effects of elective breast surgery on female embodied experience.

The phenomenological critique of biomedicine suggests that it is crucial to commit to the restoration of patient accounts and experiences in a biomedical context that views bodies as objects for repair, experimentation, and manipulation. Such endeavours, the present project included, work to reestablish humanity in the often sanitized and systematized atmosphere of biomedicine. At the same time, I also recognize, via Ingunn Moser (2009) and Jenny Slatman (2012), that this shift in thinking risks generating a “dualistic reality” wherein “theories of the body that analyze the meaning of embodiment from the perspective of social norms and (power) relations reduce the body to a social-cultural construct that is opposed to the individual biological-genetic body in biomedicine” (Slatman 2012, 284; Moser 2009). Following Moser and Slatman, respectively, I consider the meaning of individual “lived bodies” against the background of a “social-cultural ideal of embodiment” (Slatman 2012, 284). In this project, I engage elective breast surgery in a manner that works to not reduce embodied subjectivity to purely social construct or purely object status. Throughout this project, I also heed the advice of Linda Finlay and Barbara Payman (2013), and maintain that “a woman’s experience of

medical/surgical intervention cannot be understood unless we take into account the wider relational and social context in which she experiences it” (146). In turn, the two empirical chapters of this project, Chapters 3 and 4, consider female bodily experience as that which is influenced by the extant socio-cultural conditions of existence but not solely determined by its subjection to these conditions. The poststructuralist framework, anchored by Foucault’s work, enables theorists to engage in a sustained analysis of these conditions.

Normalization and Discipline: The Constituted Subject of Foucaultian Poststructuralism

Foucault articulates that normalization emerges within a regime of disciplinary power, and that it thus has a particular history. In *Discipline and Punish* and in his lectures throughout the 1970s at the Collège de France, Foucault identifies a historical shift that, starting at the end of the 17th century, resulted in a reorientation of power relations in the Western European social order. At this time, sovereign power is supplanted, but not wholly replaced, by disciplinary power. This development was galvanized by significant population growth and population migration into cities, which engendered the establishment of various social institutions to deal with and manage growth through the discipline of these populations.

The appearance of secular disciplinary apparatuses marks the transformation of the orientation of power from the sovereign form to an anonymous one that regulates at the level of bodily processes. At first, such practices were isolated and carried out at a local setting, but during the 18th century these apparatuses coalesced into a broader and more coherent disciplinary system that subjected individuals within a range of social settings. There were a number of profound shifts in the organization of society that, once established, regulated a continuous and “total hold” over the conduct of individuals through the discipline of bodily action, posture, habits, behaviour, and attention (Foucault 2006, 46). In contrast to sovereign power, which rules

intermittently and by violent force, punishment, war, and ritual, disciplinary power is a form of progressive and gradual control of the physical body, enacted through continuous training and exercise. The fundamental property of disciplinary power is to fabricate *subjected* bodies (Foucault 1979, 2003b). Under the technologies of disciplinary power, Foucault suggests, “the individual” emerges and is produced as a historical reality, shaped by the normalizing technologies of the institutions, hierarchies, and structures that regulate the conduct and behaviour of the individual (Foucault 2003c). Disciplinary societies are comprised of institutions with practices that regulate the conduct of the individuals therein.

Disciplinary power exerts a continuous pressure not on offensive actions but on *potential* behaviour. Such a form of power can only emerge, Foucault says, because the body has been reconceptualized as a static but “temporal” entity that passes through a series of processes that develop over time. Once reconceptualized in this manner, biological and bodily processes can be segmented, individualized, targeted, and ultimately managed as distinct but interrelated entities. Put another way, disciplinary power is organized around the temporal body particularly as it cycles through different life and developmental processes. Once bodies “are conceived as temporally unfolding sets of functions, it becomes possible to study those processes,” determine how to influence the body, and get those bodies to perform certain functions independently (McWhorter 1999, 154). This influence is developed and exerted through observation and calculation (of developmental norms and their deviations) and by individualizing bodies through processes that characterize the body as such (McWhorter 1999). Importantly, the temporal body is the only body that can so effectively be targeted by normalizing power because of its embeddedness in the life cycle processes of development, civilization, and reproduction (McWhorter 1999; Heyes 2007a). Further, by modifying the time of life such that it becomes

conceptualized in terms of useful time and productive time, discipline can then “transform the time of life into labour power” put to work in the service of capitalism (Gros 2016, 264).

Foucault connects the emergence and sedimentation of a disciplinary society to the then-burgeoning capitalist regime. Capitalism needs to accumulate subjugated and compliant bodies that it can use to maximum output in support of unfettered economic growth (Foucault 1979, 1990, 2003b).

Significantly, the rise of disciplinary power does not mean the total elimination of sovereign power. Foucault clearly establishes that the operations of different regimes and forms of power are in a state of continual overlap. Foucault points to the nuclear family and its preservation of patriarchal systems of property as a contemporary example of this overlap. The family performs the important function of pinning individuals to the disciplinary system by enticing them to participate in school and work, but it also reabsorbs those deemed unfit for discipline. If the family failed to perform its expected functions of caring for and adequately subjecting its members to the disciplinary order, this justified the intervention of a state-organized disciplinary network. As one of the first instances of “social assistance,” this network took on a “familial mode of functioning” wherein organizations like orphanages and homes for delinquents and children at risk took in those who could not be “managed” properly by their families (Foucault 2006, 84-85). When individuals do not easily absorb into the disciplinary mechanism, a new set of mechanisms emerges in order to manage these “deviant” populations. Disciplinary mechanisms intervene upon individuals labeled “deviant” and they are then initiated into mechanisms of control and regulation that work to learn about and transform such individuals into compliance.

The primary, intended effect of such a society is not to exclude and repress those who deviate from expectations for meaningful participation in society (as in sovereign power) but rather to generate mechanisms of observation and inclusion that produce and reinvent individuals as productive in accordance with current standards for acceptability. As a result, a disciplinary society is a normalizing society. Discipline produces a homogenous social space (Ewald 1990). This distinction—the inclusion of deviance towards compliance and productivity—marks the fundamental difference between the nature of sovereign power and the nature of disciplinary power. The apparatuses that comprise disciplinary power intervene upon individuals and impose compliance at the level of behaviour, action, and attention, and thus work over time to make individuals more socially and economically functional. This intended effect makes disciplinary power a productive—though not necessarily “positive”—mode of power (Foucault 1979).

The productive mechanism is what links disciplinary power with processes of normalization. Normalization and normalizing processes are made possible by and flourish specifically within the disciplinary society. Under sovereign power, disorder and deviance were marked by a flagrant disobedience or transgression of the law; in a disciplinary society, deviance is marked by a slight departure from a norm, average, or demand (Foucault 1979). Normalizing processes are the *effects* produced by and in the disciplinary apparatus (Foucault 2007). In general, the objective of disciplinary regimes is to produce, in a given population, “new capacities according to developmental norms” (May and McWhorter 2016, 247) because disciplines define “not a code of law, but a code of normalization” (Foucault 2003a, 38). Disciplinary power establishes and enforces its codes of normalization in a progressive manner. First, it analyzes and compartmentalizes individuals, times, movements, and actions; second, it classifies these components in relation to established objectives and the best way to meet them;

third, it establishes means for the optimal control of individuals; and fourth, it fixes processes of progressive control and, from there, separates the normal from the abnormal (Foucault 2007, 56-57). Speaking about the precise notion of normalization in the disciplinary context, Foucault (2007) states:

Disciplinary normalization consists first of all in positing a model, an optimal model that is constructed in terms of a certain result, and the operation of disciplinary normalization consists in trying to get people, movements, and actions to conform to this model, the normal being precisely that which can conform to this norm, and the abnormal that which is incapable of conforming to the norm. In other words, it is not the normal and the abnormal that is fundamental and primary in disciplinary normalization, it is the norm. That is, there is an originally prescriptive character of the norm and the determination and the identification of the normal and the abnormal becomes possible in relation to this posited norm. (57)

Societies, in the disciplinary context, are therefore contingent upon the establishment and operationalization of the norm. Prior to the 19th century, the norm stood in for the “rule,” meaning that the norm was what was right or good (Ewald 1990). At the beginning of the 19th century, the relationship between the norm and the rule changes significantly, and the norm comes to stand for the “play of oppositions between the normal and the abnormal or pathological” (Ewald 1990, 140) or the concurrent expression of the preference for a particular order and aversion to the opposite of that same order (Canguilhem 1989). The norm is a socially constructed “means of producing social law” (Ewald 1990, 154) that acquires significance in the effect that it has on and produces in the individual and social body (Canguilhem 1989; Ewald 1990). This effect is the production of a common standard, created through the reference of the

particular social body to itself.

Norms internal to a population enable the measurement of both individual and statistical deviance. The norm distinguishes between the normal and the abnormal and, from there, sanctions intervention onto and into those bodies and behaviours that are marked as abnormal (Heyes 2007a). Because the body is, as noted above, understood and articulated as a set of life processes and functions, it is newly possible to establish a direction of and control over individuals through the measurement of their capacities and their overall development in accordance with or against the norm, and to intervene where necessary in order to produce efficiency and obedience. The norm “offers itself as a possible mode of unifying diversity, resolving a difference, settling a disagreement” (Canguilhem 1989, 240). It does this not by excluding that which does not agree with it but rather by including it for the purposes of transformation (Taylor 2009). The norm expresses itself as a point of reference when it is established or chosen “as the *expression of a preference* and as the *instrument* of a will to substitute a satisfying state of affairs for a disappointing one” (Canguilhem 1989, 240, emphasis added).

Accordingly, the norm becomes a way of *producing* rules. As “the principle that allows discipline to develop from a simple set of constraints into a mechanism,” the norm is a measurement that produces a common standard (Ewald 1990, 141). In this way, the norm “lays claim to power. The norm is not simply and not even a principle of intelligibility; it is an element on the basis of which a certain exercise of power is founded and legitimized” (Foucault 2003c, 50). Norms create but also legitimize conformity so that conformity is not recognized as such, or not seen as that which is produced under the auspices of disciplinary power (Taylor 2009).¹⁵

¹⁵ Foucault makes a distinction between the operation of normalization in a disciplinary society and the operation of normalization in the biopolitical regime. In a disciplinary society, the norm establishes the normal and individuals,

Further, norms become sedimented as both assumedly natural and necessary when they are uncritically accepted by the public as such and when their origins and effects go unchallenged (Taylor 2009).

Normalization, then, refers to the production of norms, or to the “standards for measurement and comparison, and rules of judgment” (Ewald 1990, 148). Normalization is a practice and a process, or a mode of observation that orders, intervenes upon, and controls bodies in order to homogenize the bodies present in the target population (Foucault 1979). Institutions, such as schools, industrialized workplaces, and hospitals, engage in the observation and surveillance of population members in order to generate norms (Foucault 1979); established norms are then enforced through the institutional regulation of deviance, where regulation is embraced and promoted not as conformity but as containing the capacity for transformation and/or the realization of “hidden potential” (Heyes 2007a; McWhorter 1999, 156). Contrary to popular and even some scholarly conceptions, normalization does not produce objects that confirm to a pre-determined type, model, or standard. Rather, normalization determines the *procedures* that establish consensus about what norms and standards prevail and predominate in society; it is the production of the standards for measurement and comparison, and it determines the rules of judgment (Ewald 1990). Normalization “requires one to understand the normal curve of a given phenomenon (behaviour, disease, economic activity), and then to arrange things...to maximize efficiency regarding the promotion or diminishing of [that] phenomenon” (May and McWhorter 2016, 249).

under its influence, come to conform to a standard. In the biopolitical era, the norm is established from many “normals,” such as statistics and the “interplay of different normalities” (Foucault cited in Taylor 2009). Even though the norm functions differently in disciplinary and bio-power—at the level of the individual in the former and the level of the population in the latter—and this reveals a distinction in these technologies of power, the hegemony of normalizing societies is what links together disciplinary power and biopower.

Importantly, normalization generates the techniques that identify deviations from the normal, because the techniques of normalization come to take responsibility for delinquent conduct or phenomena (Foucault 1979, 2003b, 2003c, 2007). The disciplines start from the norm and carry out training and measurement with reference to the norm; from there a distinction can then be made between the normal and the abnormal (Foucault 2007). Normalization creates an “interplay” between the varied distributions of abnormality and so works to align the most favourable outcome with the least favourable outcome (Foucault 2007). Normalization serves a “primary social function by regularizing human conduct” and it is embedded in the institutions that support industrial and, increasingly, neoliberal societies (Ewald 1990; May and McWhorter 2016). In terms of regularizing, one effect of normalization is that any behaviour, proclivity, and/or conduct that deviates from the norm comes to be understood as abnormal, and thus pathological. Once a behaviour is established as such, the agents of the normalizing institution examine its etiology and develop or implement regularizing mechanisms. In a normalizing society, deviant behaviours are often positioned such that they originate within the *individual* (Foucault 1979). The result is a psychological and/or medical pathologization of and eventual treatment for the individual (Foucault 2003d), which has the effect of converting deviant behaviours into specific categories of existence and character that are newly applied to the individual rather than to conduct or behaviour.

The individualization of deviance is attributable in part to a dramatic shift that occurred in the function of expert psychiatric opinion in the legal system. In penal cases of the early 19th century, expert psychiatric opinion functioned to help police determine whether an individual was responsible for the crime that they were alleged to have committed. In the 20th century, technologies of normalization inserted themselves in the penal system and functioned, through

expert opinion, to not only construct but also take responsibility for the “delinquent” or “abnormal” individual accused of a crime. Now, the role of the “expert” and the function of their opinion is to comment on the context *surrounding* the event of the crime and to testify to its cause, motive, and origin in order to demonstrate that the individual “already resembles [the] crime before [they] have committed it” (Foucault 2003c, 19). Psychiatric opinion, in the penal context, is shaped primarily by interest in and assessments of danger and perversion and, in its assessment of these abnormalities in the penal context, effectively turns the psychiatrist into a judge (Foucault 2003c). In this way, expert psychiatric opinion comes “to pass from action to conduct, from an offense to a way of being, and to make this way of being appear as nothing other than the offense itself, but in general form, as it were, in the individual’s conduct,” which effectively twins the offense with criminality (Foucault 2003c, 16). The effect of this operationalization of expert psychiatric opinion is that it leverages scientific knowledge in a manner that legitimizes “the extension of punitive power to something that is not a breach of the law”; two consequences of this extension are first that it creates the notion of the “dangerous individual” with the desire for crime and the potential for recidivism and second that it justifies the regulation of this individual in and by the penal system, or facilitates their transition from accused to convicted (Foucault 2003c, 18, 22). At the behest of the “psychiatrist-judge,” pathologized *behaviours* eventually became pathologized *identities* that marked individuals and subject positions.

Body Image as a Product of the Psy-complex

The pathologization of certain behaviours, tendencies, and eventually identities by psychology and psychiatry and their associated institutes have been thought together by Foucault and others as the “psy-complex.” The psy-complex is comprised of the human sciences, including psychology, psychotherapy, psychiatry, and psychoanalysis and is named as such because it is a “heterogeneous network of agents, sites, practices and techniques for the production and dissemination, legitimization, and utilization of psychological truths” (Rose 1996, 60). In the 18th and 19th century, the psy-complex emerged particularly as a means to enforce disciplinary power because the psy disciplines functioned at the levels of the individual and interiority. The psy-complex collaborated with the family and took responsibility for the “rehabilitation of individuals suffering from an abnormal psychology” (Binkley 2011, 89). Through the participation of doctors and asylums, the psy-complex supported the “refamilialization” and eventually resocialization of unfit individuals by constituting itself “as the authority responsible for the control of abnormal individuals” and those deemed delinquent (Foucault 2006, 25, 42). It accomplished this through the disciplinary “production of the psychologized individual as essentially a docile subject of the very apparatus that stood poised to interpret the truth and implement [their] rehabilitation” (Binkley 2011, 90). By the outset of the 20th century, the psy-complex was an integral mechanism in “the discourse and control of all disciplinary systems” (Foucault 2006, 86). Throughout the 20th century, psychological expertise and knowledge disseminated, and became, with the rise of the welfare state, a means for coordinating individuals into social institutions (Binkley 2011); eventually, the psy-complex emerged as a primary instrument of social governance (Rose 1990).

Given their express regulatory and disciplinary function, Foucault found the psy disciplines to be dangerous. For Foucault, the psychological sciences are essentially “techniques for the disciplining of human difference,” accomplished through the systematic identification, classification, recording, and management of human variability (Rose 1996, 105). The effect of this discipline is the simultaneous depoliticization and individualization of people and their problems. In its inordinate focus on the individual in lieu of an interest in the social context, the psy disciplines “claim to give us knowledge about ourselves, about human beings, [and] about human nature,” which in turn denies humans the possibility of being otherwise for fear of being labeled deviant or dysfunctional (Taylor 2014, 405). Because psychology and psychiatry problematize and aim to regulate behaviour at the level of the individual, they can thus be affiliated with disciplinary power. For Foucault, psychology and psychiatry merely “represent and embody the norms, morality, or values of a particular society,” and subsequently encourage patients and individuals to accept and adhere to these norms (Taylor 2014, 408).

In psychology (and popular culture), the idea or notion of body image is immediately associated with how people think and feel about their bodies. Textbooks and research studies in and adjacent to psychology suggest that body image is “a person’s perceptions, thoughts, and feelings about [their] body” (Grogan 2008, 3). Typically, body image is presented as a perception of the body that we ascertain through the correspondence between cognition and reality or affect and emotion (Blood 2005). Sarah Grogan (2008) explains that, as a concept, body image combines psychology with perceptual factors but also acknowledges that body image is equally influenced by social and cultural factors. Grogan (2008) identifies four categories of the body image: *subjective satisfaction* (evaluation of the body); *affect* (feelings

toward the body); *cognition* (beliefs about the body); and *behaviour*. If the correspondence between the objective and subjective aspects of lived reality break down, a person is said to be suffering from body image dissatisfaction or disturbance (Blood 2005). Psychologists remain interested in the causes of body image dissatisfaction as well as in the possible origins of the dissonance between perception and reality. Although body image is widely considered to be a “subjective” perception and therefore an idiosyncratic phenomenon, researchers recognize that it is constructed socio-culturally through a combination of external influences including media, friends, and family, all of which can influence a person’s perception of themselves (Grogan 2008). Internal disturbance is often said to be provoked by the unrealistic and fraudulent aesthetic ideals that pervade Western society as they are reinforced as normative and desirable by various media.

Body image is a concept and a measure that is directly connected to the psy disciplines through its origin in and continued affiliation with the psychological sciences. As a set of psychological theories, it has been elaborated upon as well as empirically tested for decades by psychologists (Blood 2005). It is in the empirical measurement and evaluation of individual body image that the disciplinary effects, and thus the work of the psy-complex, become apparent. The first empirical studies of body image subjected primarily female participants to tests of bodily orientation and perception. Beginning in the 1960s, these initial experiments investigated research subjects’ visual perception of the objective reality of their body (e.g., Bruch 1973; Shontz 1969; Traub and Orbach 1964). Researchers subsequently analyzed these results in terms of their accordance with the established theory of body image as the degree of coherence between the internal perception of bodily appearance and the material reality of bodily appearance (Blood 2005). These studies, which became foundational in establishing body image

issues and continue to be carried out, found that people do not accurately perceive the size and shape of their bodies as they objectively exist in reality, and determined that women in particular have a tendency to overestimate the size of their bodies. The degree to which participants' "results" aligned with the established notion of body image as a level of (in)coherence between interiority and materiality led to the determination of common standards of "normal" and "pathological" body image, and subsequently to the stamping of these categories onto individuals. Such research established and sedimented the diagnostic notion of "body image disturbance," or the disjuncture between the *perception* of the body and the *reality* of the body.¹⁶

Because of its origins in and connection to psychology, body image can be identified as a product of the psy-complex. However, there are other aspects of the discourse, study, and treatment of body image that illuminate its association with psy. Body image is first a theory of what constitutes a "healthy" or "normal" relationship between perception and materiality and, consequently, a measure that has anchored decades of empirical research aimed at evaluating the ab/normality of a subject's body image. One predominant outcome of this research is the prescription of recommendations for those who fall outside the parameters of "normality." When psychologists conduct studies of body image and accept the results of those studies as prescriptive of normality or pathology, psychology effectively regulates "an object of its own invention" (Taylor 2014, 408). The theory and empirical study of body image and the subsequent treatment of body image issues occurs within the psy disciplines and is also organized by discipline because individuals who express or are diagnosed with body image issues are invited to participate in a disciplinary regime intended to transform their unhealthy body image into a healthy body image. The healthy body image apparatus includes counselling, psychotherapy,

¹⁶ It is beyond the scope of this project to detail the history of empirical research on body image in different paradigms in psychology. For a comprehensive review of the hypotheses, design, and results of these experiments, and a critique of the assumptions that anchor them, see Sylvia Blood's (2005) *Body Work*.

self-esteem and/or body confidence workshops, online education tools, and weight loss and exercise regimens, any or all of which are presented as ways to help people “deal with” (i.e., fix) their body image issues in a way that returns them to a state of body and self-confidence. It is in these ways that body image intersects with discipline is thus recognizable as a product of the psy-complex. The theory and study of body image is an attempt to give us knowledge about human beings and human behaviour and the empirical study of body image takes it up as an object made measurable by the very discipline that created it. Consequently, the diagnosis of body image issues and the move towards restoring “healthy” body image works in the interest of regulating difference and suppressing deviance by supporting individuals’ compliance with extant norms of human behaviour.

Feminist Engagements with Body Image

Today, body image is typically defined, in mainstream psychological literature and in popular writing, with some reference to Schilder’s (1950) definition that it is “the picture of our own body which we form in our mind, [or] the way in which the body appears to ourselves” (11). Some scholars feel that there has been a reduction of body image to an internal representation of physical appearance that “has little relationship to Schilder’s original theoretical ideas” (Hanley 2005, para. 2; Blood 2005). The body image is now understood, in popular culture and in mainstream psychology, as the feelings that one has toward their bodily appearance in combination with the internal image that one has of the outward appearance of their body. Since Schilder, a large body of theoretical and empirical research on body image has developed, with scholars working to understand and think through the significance of body image in our everyday lived experience, but also how the body image is affected by representations of the body that are outside of ourselves. It is important to consider this dominant understanding of body image in

order to briefly convey the historical origins of body image, outline how the concept has evolved, and examine how it is currently deployed in mainstream psychology, particularly because it is the conceptual point of departure for the two empirical studies that follow this chapter.

What we now understand and accept to be the supposedly ideal body in Western culture and society is ordinarily traced back to the shift in aesthetic standards in the art, fashion, and media produced at the end of the 1800s. This shift is marked by the socio-cultural degradation of overweight alongside the idealization of slenderness in women and muscularity in men.¹⁷ Feminist theorists and historians have outlined this shift in great detail, emphasizing that, at this time, thinness came to symbolize control and containment, while fatness came to represent a lack of willpower (e.g., Bordo 2003; Gilman 1999).¹⁸ Researchers concerned with body image ideals and disorders emphasize the history of this development of the “ideal” body, and point out that while grooming, adornment, and dieting have long been part of human societies, the cultural idealization of thinness is a phenomenon that developed relatively recently and emerged in combination with early 20th century trends toward more revealing fashion styles, diets for the purpose of becoming thin, and the growing strength of thinness as tantamount to healthy. This trend solidified as standard over the 20th century, and is presently bolstered by the 21st century “war on obesity” that demonizes fatness as inherently unhealthy and unattractive.¹⁹ Therefore, even though body image is often represented as a perception of the body that is developed

¹⁷ These standards were apparently also present as early as the Roman Empire, which despised obesity and idealized slenderness (Grogan 2008).

¹⁸ In mainstream media and to the general public, overweight is associated with characteristics of ill health, but these claims are widely disputed by health practitioners and scholars (Bacon and Aphramor 2014), sociological and legal scholars (Kirkland 2008; LeBesco 2004) and fat activists (Cooper 2012; Wann 1998).

¹⁹ The construction of obesity as a false epidemic rooted in fat-phobia has been covered widely in sociological and feminist literature (Campos 2004; LeBesco 2004; Lupton 2013; Murray 2008) and much has been written about resistance movements (Cooper 2012; Cooper and Murray 2012).

internally, it is widely accepted that external influences play an integral role in shaping the perception that we have of our bodies.

Currently, researchers in health studies and psychology as well as health care practitioners focus on the impacts of thinness and beauty ideals for women and girls in particular. The fact that women tend to be dissatisfied with their bodies is almost accepted as an expected and unavoidable aspect of life for women in Western countries. This increase in interest, awareness, and discussion of body image aligns with the rise in disordered eating and body dissatisfaction in the 1970s, as research into body image was conducted to explain and treat destructive body practices (Cash 2004). Research into body norms and body image disturbance suggests that the unrealistic expectations that produce body image dissatisfaction are detrimental to female psychological development and personal well-being because they encourage women and girls to undertake diets and fitness regimes that can be psychically and physically dangerous (Crook 1991; Grogan 2008). Most theoretical and empirical research on female body image problems emphasizes the need for media and society to promote “healthy” and more representative body images for people. This research also suggests that we must acknowledge that the development of a healthy body image cannot happen unless individuals have the requisite support and until we see a transformation in our social norms (Grogan 2008). Despite its ubiquity in contemporary Western culture, it is rare to encounter critiques of body image research and discourse, although there are some exceptions. Sylvia Blood (2005) as well as Kate Gleeson and Hannah Frith (2006) study body image research in experimental psychology and reveal many of the implicit biases and assumptions that undergird the concept. Blood (2005) critiques the way that body image research reinforces established truths without considering alternative engagements with the body and finds that body image discourse produces for women

a restrictive repertoire of ways to relate to our bodies. Gleeson and Frith (2006) also question the validity of body image as a concept and a measure. They examine how body image research rests upon a number of assumptions that, despite researchers' claims about the complexity of body image, actually "create a simplistic and fixed model of body image" (80).

Importantly, the question of "body image," entrenched as it is in the manufacture and perpetuation of aesthetic ideals, has also troubled feminist theorists and activists. Since at least the early 1990s, feminists have attended to the idealization of thinness and the physical appearance and its implications for women's self-perception of their bodies (Spitzak 1990). Feminists have also traced the expectations that cause body dissatisfaction to extant patriarchal norms about female bodies, which are then communicated to women throughout fashion, art, photography, film and television, advertising, and magazines (Bartky 1990; Bordo 1993; Morgan 1991; Wolf 1997). Feminists have connected these limited representations to body dissatisfaction, noting that the pervasiveness of these images provokes body hatred in women, which has very real consequences for women's survival and flourishing in patriarchal culture. Some have focused on how dangerous it is for women and girls to subject themselves to diet and extreme exercise (Bordo 1993; Wolf 1997) while others have argued that the growing concern and preoccupation with appearance that women are persuaded to have are part of a larger socio-cultural backlash against the gains of "second wave" feminism (Faludi 1991). Overall, feminist thinking and writing about body image explicitly connects body image ideals and body dissatisfaction to ideas about female bodies that have their origins in and are upheld by patriarchal cultural and social institutions.²⁰ Feminist approaches attribute these unrealistic ideals

²⁰ Notably, there is an acknowledgement of the problems of body image distortion and its impact on men (e.g., Atkinson 2008).

to social pressure and a society and culture preoccupied with youth, thinness, fitness, control, and success.

Research conducted by feminist theorists, feminist psychologists and feminist health care professionals has established that fraudulent aesthetic ideals originate in popular and social media and pervade Western societies. Such research has also established that women and girls are conditioned not only to believe in the desirability and legitimacy of these ideals but also to actively and continuously work towards them (e.g., Grogan 2008; Orbach 1978; Spitzack 1991; Bordo 1993). As a number of thinkers have demonstrated, women's acceptance of and/or confrontation with aesthetic ideals leads to an internalization of them. Women then engage in self-surveillance, viewing themselves through the patriarchal gaze (Bartky 1990; de Beauvoir 2011; Young 2005). Feminist psychologists Barbara L. Fredrickson and Tomi-Ann Roberts (1997) developed Objectification Theory, which establishes a model for measuring the effects of objectification on women. Fredrickson and Roberts (1997) suggest that, under socio-cultural conditions of sexual objectification, women are "coaxed to internalize an observer's perspective" of themselves (Fredrickson and Roberts 1997, 179; Tiggemann and Lynch 2001). In young and adult women, objectification produces a state or trait of "self-objectification" that is experienced to varying degrees and at varying moments over the life span (Fredrickson and Roberts 1997; Tiggemann and Lynch 2001).²¹

Self-objectification generates in women a hyper-awareness and "habitual monitoring" of the body in which they police their appearance and bodily expression against the judgment of an

²¹ Researchers distinguish between trait and state self-objectification. Gay and Castano (2010) state that "trait self-objectification (TSO) develops from the internalization of this external perspective on the self, and refers to the overall propensity to view oneself through the lens of others" (695). State self-objectification (SSO) is "the similar experience that is triggered or enhanced by the context; viewing pictures of models in a magazine, getting cat-calls from people on the street, or being the target of a sexually-explicit gaze from a co-worker" (Gay and Castano 2010, 695).

omnipresent, patriarchal gaze (Fredrickson and Roberts 1997; Tiggemann and Lynch 2001). The internalization of objectification encourages women to engage in continual self-surveillance at the level of conduct, attention, posture, appearance, and habit. Women in turn comply with socially sanctioned body practices (e.g., makeup, skin care, exercise, dieting and certain modes of dress) in order to project to the social world a perfectly disciplined body. But self-objectification can leave women feeling shameful and/or anxious about their bodily appearance and expressions. Feelings of shame and/or anxiety can subsequently instigate or mediate a relationship between self-objectification and sexual anxiety (Steer and Tiggemann 2008) or disordered eating (Noll and Fredrickson 1998). When a woman is feeling objectified—preoccupied with or distracted by bodily appearance, conduct, or expression or the reception of her body by others—she may have difficulty fully immersing herself in certain physical challenges or tasks (Aubrey and Gerding 2014; Fredrickson and Roberts 1997; Quinn et al. 2006). For example, a study of adolescents' engagement in sport found that girls who reported being teased during sport also reported higher levels of self-objectification and body image concerns (Slater and Tiggemann 2011). Other research on self-objectification has considered the connection between self-objectification and body image and has established that self-objectification is a significant variable in the context of body image. Some studies have shown that individuals who express a tendency to self-objectify are in turn more likely to experience body image dissatisfaction or disturbance (Harper and Tiggemann 2008; Slater and Tiggemann 2011).

Objectification Theory has been extended to consider a range of socio-cultural practices and contexts. Feminist psychologists have studied expressions of shame in women who engage in pubic hair removal practices (Smolak and Murnen 2011). Others have found that women who

experience self-objectification were more likely to express support for aesthetic surgery (Calogero et al. 2010). A study of women who work in contexts where sexual objectification is “promoted and socially sanctioned,” found that women engaged in high levels of self-objectification and experienced negative consequences such as sadness and “depressed mood” (Moffitt and Szymanski 2011, 69, 86). More recent research on self-objectification has started to consider predictors of self-objectification, examining the role of social media in women’s and girls’ experiences of self-objectification. These studies have found that the comment-centric culture that social media promotes correlates with self-objectification and increased self-surveillance (Daniels and Zurbriggen 2016; Slater and Tiggemann 2015). Objectification Theory, which evolved from feminist interpretations of Foucault’s insights into the disciplining of bodies and bodily conduct (McKinley 2011), is a powerful example of how discipline and normalization function in women’s lived experience under patriarchy. Women live with and in relation to objectification in multiple aspects of their lives; in turn, self-objectification and its effects on bodily conduct, attention, and expression exemplifies the steady disciplinary control of the female body in cultures that support and/or endorse the sexual objectification of women.

Feminist Poststructuralist Critiques of Biomedicine

Feminist examinations of women’s health and health care extend beyond questions of body image and beauty ideals and regimes and into critiques of biomedicine as a system that also generates negative effects for women’s bodies and well-being. Poststructuralist critiques of biomedicine are interested in examining biomedicine as a “sociocultural artifact” and social phenomenon, and challenge the assumption that it is a progressive practice that is not only impartial but also unencumbered by society and culture. This work is largely informed by the insights of Foucault, and considers the significance of social and cultural norms. Foucault’s

(1990, 2000, 2003d) work establishes that the networks of power that regulate social institutions like the clinic, prisons, education, and the law, produce sets of knowledge and experience (Foucault 2003d). Foucault (2000, 2006) traces how the development and sedimentation of diagnostic processes in the 18th and 19th centuries led to the interpretation of some behaviours as “normal” and others as “abnormal,” and suggests that this produced conditions like “mental illness,” which he then understood to be a product of the social structure. Foucault (2003d) also identified that power “produces” the body by rendering it an object of control and regulation; in the context of medicine this occurs specifically through the routinization of certain practices, like the physical examination of the patient, and the development of specialties like surgery, which is one based on the continuous monitoring and surveillance of patients. As Deborah Lupton (2003) writes,

the medical encounter is a supreme example of surveillance, whereby the doctor investigates, questions, touches the exposed flesh of the patient, while the patient acquiesces, and confesses, with little knowledge of why the procedures are carried out. In the doctor’s [office], the body is rendered an object to be prodded, tested and examined. The owner is expected to give up his or her jurisdiction of the body over to the doctor.

(4)

Foucault isolates the body because, for him, it is the crucial site for ideological and political regulation of the general public. He demonstrates how the development and inculcation of “public health” in the late 18th century turned toward preventative care and health and hygiene promotion that in turn compelled individuals to regulate their own behaviours and discipline their own bodies so as to not only prevent illness and disease but also to adhere to “proper” corporeal conduct (Foucault 2000). Foucault’s insights demonstrate that contemporary health

care and medicine encourage individual subjects to “take responsibility for maintaining personal bodily health” (Lupton 2003, 33) in ways that not only discipline bodies but also encourage individual self-surveillance (Rose 2007). In turn, poststructuralist feminist engagements with health care and biomedicine work to uncover the socially, culturally, and historically contingent assumptions, beliefs, and understandings that not only work toward the social discipline of female bodies, but also to undermine biomedicine’s claims to objectivity and neutrality. This research is unified by a sustained focus on exposing the discursive and regulatory practices that are embedded in and perpetuated by a shift toward biomedicalized and geneticized thought and treatment of women’s bodies and health. Ultimately, poststructuralist feminist engagements with biomedicine and health care reveal how and in what ways women’s “bodies are constituted through technological and scientific practices that are part of, rather than outside of, culture and power” (Mamo and Fosket 2009, 927).

In the early 1990s, feminist thinkers began to assert the usefulness of Foucault for feminism, specifically because, as noted above, he emphasizes the body as a primary site of the “operation and exercise of power” (McLaren 2002, 81). Foucault’s work contributes to feminist understandings of the “material conceptualization of power, history, and subjectivity” (Alcoff 2000, 52). At the same time, feminist thinkers are simultaneously critical of his neglect of the gendered nature of power and embodied experience. Feminist critiques widely acknowledge Foucault’s neglect of the gender specificity that is inherent in the disciplinary practices carried out on the body (Bartky 1997; McLaren 2002) as well as his failure to acknowledge the significance of male dominance in the historical periods he was investigating (Alcoff 2000; Shildrick 1996). Foucault did not acknowledge that disciplinary mechanisms and regulatory controls treat female and male bodies differently, particularly to the extent that the male body is

the untroubled “norm” and the female body becomes problematic and pathological by contrast (Alcoff 2000; McNay 1992). As a result of always being against the norm, women’s experiences of power are always different insofar as certain forms of subjugation serve to produce a body that is specifically feminine, particularly in terms of size, appearance, constitution, gesture, and ornamentation (Bartky 1997; Young 2005).

In response, feminists have extended and revised Foucault’s oeuvre to include gender, and many have extended his analysis of power and biopower to emphasize its intervention into and onto female bodies. There is now a large oeuvre of feminist-Foucaultian scholarship that draws attention to issues of women’s health and reproduction, including issues of reproductive rights and justice (Mills 2011; Palmer 2009; Rodrigues 2014; Ruhl 1999; Sawicki 1991; Terry 1989; Waldby and Cooper 2008) and related issues such as genetic screening (Polzer and Robertson 2010), and Assistive Reproductive Technologies (ARTs) (Rapp 1999; Inhorn 2009; Sawicki 1991). Such inquiries extend from radical feminist critiques that position biomedicine as a dehumanizing set of institutions that do not support women’s health and well-being (e.g., Corea 1985; Frankfort 1972). Together, these efforts reveal the systematic processes through which biomedicine produces female and feminine bodies, and show how women’s bodies are disciplined and regulated by the medicalization of reproduction, pregnancy, and childbirth. Recent analyses have explored how the regulation of bodies and populations in the context of genetic risk and pre-natal genetic testing signals a new era of biopower enacted at the molecular level (Shildrick 2004; Taussig et al. 2003). Others have explored the intervention of biopolitics in the medical management of breast cancer (King 2006; Klawiter 2008). A feminist perspective has not only expanded the limits of Foucaultian inquiry, it has used this broadened frame to demonstrate how female bodies—especially and disproportionately—are uniquely subject to

biomedical regulation as a result of the medicalization of women's health that grew alongside the modernization of medicine in the 19th century.

Feminist Foucaultians have also shown that women are disproportionately targeted for surgical intervention. This is especially well-established by the feminist Foucaultian examination of aesthetic surgery as an extension of beauty regimes (Balsamo 1992; Bordo 1993; Brooks 2004; Fraser 2003; Heyes 2007a, 2007b, 2009; Morgan 1991; Weiss 2014). Once modern surgery became useful to a larger, social project of "improving" bodily appearance, it became integral to the determination and regulation of the morphology and aesthetic appearance of female and feminine bodies, respectively. In turn, the majority of empirical and theoretical investigations of surgery, at least in the social sciences and humanities, are and have been conducted by feminist thinkers interested in the implications of aesthetic surgery for embodiment and subjectivity in a patriarchal context.^{22, 23} This feminist work has been primarily anchored by an interrogation of the relations of power that inform and are embedded in women's ever-increasing engagement with aesthetic surgery. This scholarship has been varied, with feminist theorists focusing their attention on a complex array of concerns that examine how aesthetic surgery has shaped the body and embodiment. While some feminists have examined the oppressive effects of aesthetic surgery (e.g., Bartky 1990; Bordo 1993; Morgan 1991; Wolf 1997), others have attended to its role in identity formation (Gimlin 2002, 2006; Pitts-Taylor 2007, 2009), its ability to alleviate psychological suffering (Davis 1995, 1998, 2003); its contradictory production of individuals via normalizing practices (Covino, 2004; Jones 2008) and its capacity for creative self-making (Heyes 2007a).

²² Feminist scholars have also examined the ways in which biomedicine has taken responsibility for and sanctioned surgical interventions on trans bodies (Salamon 2010; Sullivan 2008) and intersex bodies (Feder 2006, 2014; Roen 2008).

²³ There is also a growing interest in men's uptake of cosmetic surgery (e.g., Atkinson 2008).

Like the Foucaultian-feminist work cited here, this dissertation project draws primarily on the works that comprise Foucault's "genealogical" period. It is important to pause for a moment and consider why the work in Foucault's genealogical period is most relevant to this project. Foucault's body of work is typically classified as having three "phases"—archaeological, genealogical, and ethical—that parallel the chronology of his publications. The majority of Foucaultian-feminist theorists reference Foucault's genealogical period particularly because this is the point at which Foucault engaged his most focused meditation on the operation of power, structures of discourse, and techniques of control, with a specific emphasis on the effects of power on the body and the subject. Genealogy has a clear methodological and political overlap with feminist theoretical and political projects. For instance, in an interview, Foucault (1988) stated that genealogy is a method for dissecting "the present time" in order to challenge the systems of thought that have become "familiar and accepted"; feminists, too, seek to interrogate and consider the effects of taken-for-granted social and political structures.

For Foucault, genealogy is a mode of historicizing that reveals "the controlling structures that operate below the level of human subjectivity" (Gutting 1990, 343). Instead of examining historical phenomena through a focus on the intentions or aims of particular *actors* in human history, genealogy focuses on the *effects* of social structures on human subjectivity (Gutting 1990; McLaren 2002). Thus, because this dissertation project investigates the structures and normalizing effects of contemporary surgical discourse and practice, it makes sense to analyze it by engaging Foucault's genealogical work. Foucault's inquiry into the techniques of normalization and discipline and their effects on subjects is a sensible starting point for this project because it is the time at which Foucault most acutely focuses on "the causal processes that operate on the human body" (Gutting 1990, 335). In this project, I employ Foucault's

articulation of normalization and discipline in the context of elective surgery to interrogate how the notion of the body image is formulated and functions both as a “concept” in and of itself and as a means by which to regulate women’s bodies and subjectivities. But, because Foucault’s genealogical inquiry emphasizes structures and practices and does not account for first-hand experiences, this project turns to phenomenology to emphasize and consider the lived effects of power. The phenomenological part of this project takes up women’s first-hand, narrated experiences in order to, as outlined earlier, attend to what women do with the concept of body image and how they live their bodies anew as a result of elective breast surgery. Given this pairing of Foucaultian poststructuralism with phenomenology, it is important to note that much philosophical discourse has focused on Foucault’s fraught relationship with and “rejection” of phenomenology. In turn, before this project can begin the work of theorizing elective breast surgery from a poststructural-phenomenological framework, it must first acknowledge the conflict between these two frameworks and reconcile some of the differences that have been identified between them. Contemporary feminist works that intersect with phenomenology and/or poststructuralism have elaborated upon and subsequently harmonized the major thematic points that exist between Foucault’s poststructuralism and Merleau-Ponty’s phenomenology.

The Compatibility of Phenomenology and Poststructuralism

Foucault’s poststructuralism has a contentious relationship to phenomenology. There are supposedly fundamental points of disagreement between phenomenology and Foucault to the point that his project is often represented as divergent from phenomenology. It is thus important to address Foucault’s relationship to phenomenology, which resulted in his “rejection” of phenomenology, as well as the specific points of his opposition, which have been identified by poststructuralist and phenomenological thinkers. It is also necessary to articulate the points of

convergence and highlight recent scholarship that supports the alignment of Foucaultian poststructuralism with Merleau-Pontian phenomenology.

Foucault was not always opposed to phenomenology; he was a student of Merleau-Ponty and his early writings are considered phenomenological (May 2005). Phenomenology served as a point of departure for Foucault's early intellectual and professional work. He earned several qualifications in psychology and, after that, he worked in psychiatric hospitals (Gutting 2013; May 2005). His work at these hospitals connected him with Ludwig Binswanger, a psychologist who took an existential-phenomenological approach. Foucault translated Binswanger's *Dream and Existence* into French and wrote for it an introduction entitled "Dream, Imagination and Existence"; this introductory essay is considered his first phenomenological work, for it is replete with then-current phenomenological themes (May 2005). Foucault's first book, *Maladie mentale et personnalité* (1954), is considered phenomenological (May 2005). In both of these works, Foucault is concerned with the question of freedom as it intersects with world-making and with a critique of psychology's reduction of the subject of madness (May 2005). Shortly thereafter, however, Foucault began to distance himself from phenomenology and, over time, actively rejected these early phenomenological works as being part of his oeuvre (Kruks 2001).

Several contemporary theorists, including Sonia Kruks (2001), Leonard Lawlor (2014), Todd May (2005) and Johanna Oksala (2016), have traced the shifts in Foucault's work that demonstrate the shrinking influence of phenomenology on his thought and his eventual break from phenomenology. Kruks (2001) and May (2005) point out that it was after publishing *Maladie mentale et personnalité* that Foucault's methodological and conceptual approach shifted, and his intellectual project began to explicitly critique phenomenology. Foucault challenged the claim, which he found in Husserl's phenomenology, that history has a teleology.

In Husserl, Foucault identifies an appeal to transcendence that “turns history into a continuous progression from an originating intention to a final purpose”; Foucault disagrees with this appeal and distances himself from any reference or adherence to “terminal truths” (Lawlor 2014, 339). Foucault’s history, by contrast, does not recall an “original intention” nor does it “lead forward to an endpoint”; both his critique of phenomenology and his analyses of history mark an attempt to “escape” from the enclosure of “origin and end” (Lawlor 2014, 340, 342).

Foucault’s thinking changed as a result of the growing influence of Nietzsche and Canguilhem on his perspective. A shift toward a genealogical approach, in part, necessitated Foucault’s turning away from phenomenology. Although phenomenology and genealogy can and do attend to the shared problematic of human experience, their respective treatments of the subject are divergent. Specifically, phenomenology “requires the subject to play a founding role” through its emphasis on description rather than explanation of experience; in contrast, a genealogical approach necessitates taking “the subject as more constituted than constituting. It is not subjective experience, but rather the formative history of that experience, that becomes the relevant subject matter” (May 2005, 302). Nietzschean genealogy rejects the “authority of the subject” that is common to the phenomenological reduction and it emphasizes the *history* of experience over the *subjective nature* of experience (May 2005, 302; Crossley 1994). In his preface to Canguilhem’s *The Normal and the Pathological*, Foucault (1989) acknowledges the opposition between a philosophy of experience and a philosophy of rationality, and aligns Canguilhem with the latter approach, in turn rejecting phenomenology. In aligning with Canguilhem, Foucault positions himself as undertaking an approach to knowledge wherein knowledge inevitably intersects with history and cannot be solely located in the subject’s experience (May 2005). The primary point of contention between Foucault and phenomenology

is marked by his investigatory preference for social structure over individual experience, as, with genealogy, “it is no longer the experience of the subject that is to be interrogated, but the categories within which that experience is articulated” (May 2005, 306).

Foucault’s split from phenomenology surfaces continually in feminist philosophy, particularly in the trajectory of feminist theory since the 1990s. Feminist theory, particularly feminist theories of the body, developed along two axes—one that intersects feminist thinking with Foucaultian poststructuralism and one that intersects feminist thinking with Merleau-Pontian phenomenology. Each has raised concerns about the supposed shortcomings of the other: Foucaultian feminists have expressed their hesitation with phenomenology, while feminist phenomenologists have discussed the problems with a poststructuralist framework. These sets of concerns intersect in part with how Foucault and Merleau-Ponty each treat experience, particularly because experience has been so central to feminist theory and the consciousness-raising efforts of feminist politics (Kruks 2001). There also exist among feminists concerns about how Foucault and Merleau-Ponty, respectively, treat the body and the subject (Levin 2008).

Feminist phenomenologists argue that the feminist-poststructuralist account of gender reduces women to gender, to an “ongoing discursive practice” and to the “continuous production of a social form” (Butler cited in Moi 1999, 75). They critique Foucault for devaluing “concrete, fleshy, bodily materiality” and for emphasizing “discourse at the expense of lived experience” (Levin 2008, 17). Foucault’s attention to discursivity, representation, and performativity, they maintain, reproduces the body as object and neglects to acknowledge that the body as *experienced* is not only meaningful but is also situated historically as well as culturally (Fielding 1996; Moi 1999). Feminist phenomenologists object to Foucault’s ignorance of bodily agency and his failure to take the peculiarities of gendered experience into account (McLaren 2002),

particularly where his thinking engages institutions of social control such as biomedicine. Thus, feminist thinkers who advocate a phenomenological approach critique feminist poststructuralist approaches for advancing a category of gender that builds gender upon the “objective” and “scientific” grounds of sex (Moi 1999). As a result, gender, as a poststructuralist category of analysis, does not account for bodies in their concreteness, historicity, and experientiality because gender here does not include the experiential body. To elide what is concrete, historical, and experiential about bodies is to, they argue, lose touch with lived experience. The phenomenological mode accounts for bodies in their depth (Fielding 1998) and situatedness (Moi 1999) within the world. The idiosyncrasies and individualities of human experience reveal, as feminist phenomenologists argue, that lived experience is more than “mere discursive epiphenomena” (Levin 2008, 17). Lived experience, they say, is vital for analysis, for we move our phenomenal body and not our objective body (Levin 2008).

In contrast, feminist Foucaultians have articulated the shortcomings of a phenomenological approach, arguing that it necessitates an over-reliance on lived experience that subsequently ignores the broader social conditions that shape people and our experiences. To try to access experiences that are “untouched” by discourse is, they suggest, a failed project (Levin 2008). Feminist Foucaultians suggest that the conceptualization of the body in Merleau-Ponty’s work produces an essentializing effect because it presents the body as a universal entity that is anonymous, pre-discursive, and pre-cultural (Butler 1988; Levin 2008).²⁴ They also critique the fact that Merleau-Ponty’s writings present the body as “natural” and in turn oppose the fact that the body of phenomenological inquiry is normatively male, white, heterosexual and able-bodied (although, as indicated earlier in this chapter, feminist phenomenologists themselves recognize

²⁴ On the point of essentialism, Linda Fisher (2000) argues that an account that is general need not be understood as “generic” and that, instead, the “generic” may be understood as a point of departure for the assertion of variance.

this problem (Ahmed 2006; Grosz 1994; Irigaray 1985; Weiss 1999)). The ideological struggles that exist between feminist phenomenology and feminist poststructuralism are rooted in uncertainty around how feminists ought to understand and think through the matters of human agency and subjectivity.

Recent feminist scholarship on the body has taken up the project of bringing Merleau-Pontian phenomenology together with Foucaultian poststructuralism, with emphasis on these points of supposed divergence. Feminist philosophers have suggested that the focus on the body in feminist philosophy marks an appropriate point of departure for aligning phenomenology with poststructuralism, given that both frameworks are also concerned with the body and subjectivity (Kruks 2001; Levin 2008; Oksala 2004, 2016). Some feminist phenomenologists have, in working to reconcile phenomenology with poststructuralism, systematically refuted the charges that poststructuralists have leveled against phenomenology (Stoller 2009, 2010). As articulated above, Foucault's work has been useful for feminists because it demonstrates that bodies and subjects are discursively constructed and shaped by power; this insight, in turn, helps feminists articulate the ways that power intervenes on female bodies (Kruks 2001). Merleau-Ponty's work has enabled feminists to articulate the lived experience of female embodiment in a society that undervalues and devalues that experience (Levin 2008). Thus, in drawing phenomenology and poststructuralism together, feminist thinkers are able to articulate the peculiarities of female experience by attending to the oppression of women's bodies in patriarchal societies in a manner that generates space for women's experiences.

Feminists suggest that, despite these points of difference, there are actually many points of agreement between Foucault and Merleau-Ponty. These points of commonality indicate the possibility and sustainability of an alliance between the two frameworks. On the matter of the

relationship between mind and body, both Foucault and Merleau-Ponty reject Cartesian dualism (Heyes 2007a; Levin 2008). Foucault's genealogical inquiries reveal the ways that bodies and subjects are concurrently shaped by modes of institutional power that target bodily behaviour and conduct, which indicates that the subject is not entirely contained or constructed within the mind. In understanding the body as a chain of temporal events managed in relation to norms, as outlined earlier, Foucault's genealogical orientation "supersedes the more familiar mind/body dualism" (Heyes 2007a, 23). On this point, Merleau-Ponty's phenomenology understands subjectivity and humanity as being located not in the mind but in embodied experience (Levin 2008; Merleau-Ponty 2013). Also, both Foucault and Merleau-Ponty understand the body in terms of its enmeshment with history. Foucault's (2003b) genealogical work reveals the body as "totally imprinted by history and the process of history's destruction of the body" (357). Merleau-Ponty also understands the body as an historical idea that "gains its meaning through a concrete and historically mediated expression in the world" (Butler 1997, 403).

A number of recent works in feminist philosophy analyze embodied experience by joining poststructuralism with phenomenology. Johanna Oksala's (2016) most recent work engages a defense of feminist philosophy and an exploration of feminist philosophy as a specific form of social critique. To this end, she draws poststructuralism and phenomenology together and performs a "backtracking and restrengthening" of the structural elements of feminist philosophy, revisiting both key aspects of feminist philosophy, such as experience, and the work of key feminist thinkers, such as Joan Scott, Christine Battersby, and Linda Martín Alcoff (Oksala 2016, 17). Julia Levin (2008) identifies affinities between poststructuralism and phenomenology that enable her to posit a "liberatory theory of embodied subjectivity" that also overcomes entrenched dualisms (5). In so doing, she turns to the practice of karate, to "illustrate

how bodies can be both disciplined and habitualized, fully discursive and lived, *and* involved in resistance to sexism and oppression” (Levin 2008, 20). This approach to the study of body practices reflects that of Cressida Heyes (2007a), whose engagement with yoga as a form of “somaesthetics” also demonstrates a process of bodily liberation through discipline. Yoga, she suggests, can lead “to a more expansive, unanticipated experience of our bodies” given its twinning of bodily discipline and habituation (Heyes 2007a, 132). As Levin (2008) puts it, “it is not inherently contradictory to claim that bodies can be both discursive through-and-through *and* phenomenologically lived” (3).

Feminist theorists identify at least two reasons why it is both possible and sustainable to bring these two frameworks together: first, there are several points of convergence between these two frameworks; second, they are not, ontologically speaking, fundamentally incommensurate. Levin (2008) identifies and resolves some of the key points of contention between Foucault and Merleau-Ponty, including the position of the subject and the problem of agency. First, the position of the subject necessitates considering whether human experience is the product of discourse, as per Foucault, or whether experience—and subjectivity—precede discourse, as per Merleau-Ponty. Foucault and Merleau-Ponty are typically represented as engaging contrary orientations on the matter of experience, but Levin’s (2008) examination highlights that their perspectives are more closely aligned than previously articulated; namely, a closer reading of Foucault and Merleau-Ponty reveals that discourse and experience are co-constitutive. She suggests that both Foucault and Merleau-Ponty appeal to experience “in a way that fully recognizes and takes account of the discursive elements that contribute to it” (Levin 2008, 159). The difference is in the *level* of analysis: Foucault engages a third-person analysis of experience and Merleau-Ponty offers a first-person account (Steele, cited in Kruks 2001). Levin (2008)

points out, as does Oksala (2004), that Foucault's work does not elide an inquiry into experience. *The Order of Things* is presented by Foucault himself as an analysis of the experience of order (Oksala 2016). Levin (2008) also indicates that Foucault's work in *The History of Sexuality, Vol. 3*, being as it is a study of bodies and pleasures, is indeed about bodily experience and materiality. Merleau-Ponty's phenomenology, as much as it is concerned with the description of experience as it is, still emphasizes "the situatedness, localization and social and historical influences that shape experience" (Levin 2008, 162). The descriptions of lived experience in which Merleau-Ponty engages, Levin (2008) maintains, are not presented as "true, pre-existing or universal" (163); instead, the purpose of Merleau-Ponty's phenomenological orientation and his descriptive work is to bring experience into being via discourse (Levin 2008).

In addition, the conceptualization of the subject in Foucault and Merleau-Ponty—namely, Foucault's rejection of the subject and Merleau-Ponty's revitalization of the subject—is also not incompatible. Both Foucault and Merleau-Ponty "locate subjects squarely within history and discourse, incapable of acting or existing external to their discursive situations" (Levin 2008, 171). For Foucault, discourse produces varying subject positions. For Merleau-Ponty, the subject is unequivocally shaped by the typicalities of "situation" and thus does not fully or freely "create his part" in the world (Merleau-Ponty cited in Levin 2008, 170). Ultimately, on the matter of experience and the subject of experience, Levin (2008) concludes that Foucault and Merleau-Ponty offer "compatible accounts" of the subject that indicates the recognition of a co-constitution that exists between Foucault and Merleau-Ponty. She concludes that because an examination of both frameworks reveals that "all experience is discursive, and at the same time all discourse is rooted in experience," a "fuller and more comprehensive account of experience" can emerge in their enmeshment (Levin 2008, 167-8).

Another point of contention between Foucault and Merleau-Ponty concerns how the two thinkers take up the problem of agency. For Foucault (1979), the body is the product of power that renders it docile by motivating the body to internalize disciplinary habits and behaviours. In turn, the body is often understood as devoid of agency (Oksala 2016). However, even though Foucault is, in his genealogical period at least, deeply concerned with the intervention of power on subjects, and even though he does not explicitly take up the question of agency in his writings, this does not mean that his work denies those subjects their agency (Levin 2008). Oksala (2004) maintains that, in Foucault's final works, the body's agency is located specifically in its capacity to recognize its status as historically produced by discourse, and to, consequently, alter its future by imagining itself differently. Similarly, Christine Daigle (2013) points to the ambiguous status of agency in Foucault, wherein the subject is "caught in the web of its own relation to oneself and to others (consciousness and structures)" (5). In Merleau-Ponty's (2013) work, the body is presented as imbued with agency, in the form of intentionality—the "I can." His work demonstrates the body's agency by locating agency "in the lived experiences of being able to act on [and impact the world]" as well as in "the body's active potentialities and capabilities: experiencing what my body *can do* and the changes and effects its actions can have in the world" (Levin 2008, 202, emphasis in original). In turn, both Foucault's and Merleau-Ponty's work enables the possibility for a conceptualization of the body as bearing and executing agency. As Levin (2008) so astutely puts it, bodies do not have to be treated as either subjected *or* agentic: "being disciplined and being an experiencing, agentic subject are not mutually exclusive" (193).

Thus, following Levin (2008), Oksala (2016; 2004) and Kruks (2001), as well as Daigle (2013) and Stoller (2009, 2010), each of whom demonstrate the compatibility of Foucaultian

poststructuralism and Merleau-Pontian phenomenology, this dissertation engages Foucaultian poststructuralist thinking on the body to account for the way that surgical intervention is a form of power that works on female bodies and draws on Merleau-Ponty's phenomenology to attend to ways in which women live through surgical intervention. Levin (2008) points out that such a focus risks miring woman with body/nature, despite feminist rejections of this association (Shildrick 1996); however, the focus of this project is to draw on women's bodily specificity and experience in order to demonstrate the peculiarities of female embodiment within the discourse and practice of biomedicine, rather than to perpetuate the alignment of female bodies with immanence, inadequacy, or inferiority. Bringing these two theoretical frameworks together is productive, for attention to experience over the representation of sex and gender enables us to understand how individual women encounter, internalize, or reject dominant gender norms in the context of their situation (Kruks 2001; Moi 1999). Consequently, this attention to lived experience means that woman cannot be defined solely "within the narrow semantic register of sex, sexuality or sexual difference" but rather as "a human being" enmeshed in a continuous and open-ended process of becoming that is shaped by sex and gender (Moi 1999, 82-3). In bringing phenomenology together with poststructuralism, this project aims to consider the effects and impact of surgery in a manner that considers how the discourses, practices, and institutions of power (here, biomedicine) manage and modify corporeal processes and performances alongside an apprehension and articulation of the lived body and subject as they are situated therein. In paralleling these two theoretical frameworks, the limitations of each can be overcome. However, instead of doing this work at the level of theory by engaging close readings and comparisons of key texts, as Levin (2008) has done, this project activates a combined Merleau-Pontian/Foucaultian feminist theory of the body by engaging a comparative case study of the

discourse and experience of elective breast surgery in the contemporary, Western, biomedical context.

Conclusion

In this chapter, I considered the relevant theoretical literature that informs this project, emphasizing the articulation of the body and the subject in Merleau-Ponty's phenomenology and Foucault's poststructuralism, respectively. I examined some of the main points of intersection between poststructuralism and phenomenology and the context of this project. Specifically, I worked through the contributions that feminist theory of the body has made to phenomenology and poststructuralism. This chapter articulated not only the origins and conceptualization of body image/schema, but also took up the phenomenological, psychological, and feminist perspectives on body image. It also articulated the critiques of biomedicine from the point of view of phenomenology, poststructuralism, and feminist theory. Throughout, I emphasized the ways in which feminist theory of the body intersects with and contributes to phenomenology and poststructuralism, focusing in on feminist examinations of body experience, such as women's experiences of health and illness in the biomedical context, in order to demonstrate the ways in which a feminist approach challenges as well as expands the limits of these two frameworks.

Given the fact that the writings that comprise Foucault's oeuvre have been positioned as comprising three distinct tracks, it was also important to substantiate this project's focus on the work in his genealogical period. This chapter closed by reflecting upon the assumed divergences in phenomenology and poststructuralism; this is a crucial point of consideration given Foucault's oft-cited "rejection" of phenomenology. I drew on extant studies, with an emphasis on feminist theory, to demonstrate that not only do many theorists contest the fact that there is a fundamental opposition between phenomenology and poststructuralism but that there are also carefully

established and valid grounds for an alliance between these two frameworks. The next two chapters of this project, Chapters 3 and 4, are empirical studies with a theoretical underpinning that puts this recognized alliance into practice. These subsequent chapters engage two, complementary studies that aim to understand, on the one hand, how the concept of “body image” is operationalized to normalizing effect in clinical publications on elective breast surgery and how, on the other hand, women who experience elective breast surgery make sense of their bodily change in relation to the concept of “body image.”

CHAPTER 3: BODY IMAGE AS NORMALIZATION: CLINICAL DISCOURSES OF ELECTIVE BREAST SURGERY

Introduction

Aesthetic surgeons and health care practitioners who support aesthetic surgery recognize that they have a vested interest in how elective procedures impact patients' body image. Because elective surgery and body image are almost always intertwined, in that women who seek elective surgery often do so to address body image issues, the matter of body image frequently runs through women's pre- and post-operative experiences and in turn comes up as necessary for study by the aesthetic surgeons who carry out these procedures. Many surgeons and health care practitioners conduct surveys with surgical patients, engage in meta-analyses of the extant literature, or write opinion pieces, in order to explore the impact of elective surgery on body image. This group of studies emerged in the 1960s and proliferated in the 1970s alongside the increased uptake of aesthetic surgery (e.g., Jacobson and Edgerton 1960; Hollyman et al. 1986; Honigman et al. 2004; Sarwer, Wadden and Whitaker 2002). These studies have been categorized as comprising three phases: first, surgeons examined the psychological characteristics of patients from a psychodynamic perspective; in the second phase, they continued to generate and examine patients' psychological profiles but did so using standardized psychometric tests; in the current, third generation of studies, surgeons continue to use standardized tests, but do so with the intent to improve upon identified methodological shortcomings found in the previous generations (Sarwer and Crerand 2004). These articles and studies are directed toward other health care practitioners, as they emphasize post-operative patient outcomes (Sarwer, Wadden and Whitaker 2002), recommend ways to combine surgical

and professional expertise in order to provide more effective treatment (Moss and Harris 2009) and offer practical recommendations for the nurses who counsel, manage and conduct psychological assessments of patients (Crerand et al. 2007).

While there exist studies that critically examine the function of body image discourse in publications directed at women (Blood 2005; Markula 2001) and studies that consider the validity of surgeons' claim that aesthetic surgery can "fix" body image over the long-term (Markey and Markey 2015), there is a lack of studies that systematically examine how surgeons, health care professionals, and psychologists mobilize the discourse of body image in the context of aesthetic surgery. Thus, the focus of this chapter is on studies and articles conducted, written by, and directed toward clinicians and health care practitioners. Given the combination of increased social and professional interest in body image issues and the long history of the empirical studies of surgical outcomes on body image, it is important to examine the presence and effects of discourses of body image in clinical publications on breast augmentation and breast reduction surgeries. In this chapter, I analyze how clinicians understand, employ, and mobilize this concept when they publish articles on elective breast surgery and, subsequently, I consider the effects of this discourse in terms of discipline and normalization.

Chapter Objectives

This chapter offers a poststructuralist-feminist investigation of elective surgical intervention into and onto the female breast. In what follows, I examine how publications in the clinical and biomedical literature on breast augmentation and reduction make sense and use of the notion of "body image." The primary objective of this chapter is to understand how body image is deployed in predominantly clinical research that aims to understand the motivations for and outcomes of breast augmentation and reduction procedures. This chapter considers how

those involved in the provision of these procedures conceptualize and mobilize body image as a discourse, then considers the effects of this deployment. I apply feminist poststructuralist discourse analysis to literature on elective breast surgery and body image printed in clinical and biomedical publications between 1974 and 2014. The aim of this analysis is twofold: first, it establishes how body image is understood and functions in clinical literature on breast augmentation and reduction; second, it interrogates how this understanding functions in relation to surgical practice in a way that emboldens the normalizing effects of elective surgery. I read the literature with these questions in mind: What does “body image” mean in the context of this literature? How it is mobilized as a concept in the discourse about the implementation of breast augmentation and breast reduction surgery and what are the effects of its use as a concept? What narratives are told about women’s bodies and female body image in this context? How does the concept of body image shape how women’s bodies are taken up and how women are cared for in the elective surgical context?

In exploring the meanings, uses, and implications of body image that emerge and/or are perpetuated in and by this literature, I focus in this chapter on how body image and body image issues are positioned, understood, evaluated, and discussed and I consider how women and women’s bodies are positioned as subjects in relation to surgical intervention. The first section of this chapter presents an outline of the data collected for this study. From there, I analyze how the notion of body image is mobilized in clinical publications on breast augmentation and reduction surgeries. To this end, I discuss the discourse of clinical publications on breast surgery and body image along four discursive themes identified during the process of coding and analyzing the data, attending to the implications of this discourse in terms of the discipline and normalization of female bodies.

Body Image Discourse in the Clinical Discourse of Elective Breast Surgery

Methodology

This chapter engages a qualitative, discourse analysis of full-length research articles and studies published in peer-reviewed health sciences, psychology, life sciences, and medical journals.²⁵ The group of articles collected and analyzed here explores, in some way, the relationship between breast reduction and/or breast augmentation and body image, focusing on women who undergo these procedures. Using the Scopus database,²⁶ my search for [“body image” AND “breast augmentation” OR “breast augmentation”], with no filter on dates, generated a data corpus of 145 articles by conducting a search. I downloaded all available results, which were published between 1974 and 2014. After filtering out articles in languages other than English that were not caught by filters as well as articles that did not meet the search criteria (e.g., editorials; letters to the editor; articles beyond the topic-at-hand), the search produced a workable data set of 134 peer-reviewed articles.^{27,28,29} The results of this search are a set of articles that cover a broad range of topics related to body image and elective breast reduction and augmentation surgeries. They are predominantly written from a clinical

²⁵ For brevity’s sake, and given that the articles and studies are produced for and/or by clinicians and/or health care practitioners, I shall refer to these articles and studies in a general sense as “clinical publications.”

²⁶ Scopus is the largest database of peer-reviewed literature that offers significant advantages over other comparable databases like PubMed and ProQuest. Like PubMed and ProQuest, Scopus provides results in biomedical disciplines, but Scopus also includes the health sciences, life sciences, and physical sciences. It includes books and book chapters as well as journal articles. The greatest benefit of choosing Scopus for a study like this one is that Scopus provides links to full-text PDFs; thus, it offers a significant advantage for workflow and project management in comparison to, say, PubMed, which only provides citations.

²⁷ A number of articles, for example, are on the topic of breast reconstruction following mastectomy and thus could not be included. At the same time, articles that considered breast augmentation or reduction alongside other procedures not covered by this study (e.g., liposuction; rhinoplasty) were included in the analysis. Also, three articles on adolescents were relevant to the question of body image and thus were included.

²⁸ The majority of the results were downloaded as PDFs via Scopus links. Any articles that were not available for download through the institutional databases were acquired using RACER (interlibrary loan). Two of the articles were book chapters and they were retained and included in the study. Four articles that were neither available online nor via RACER were entirely irretrievable and were thus excluded from the study.

²⁹ To maintain a manageable data set, I did not mine article reference lists for additional data.

perspective by psychiatrists, psychologists, aesthetic and reconstructive surgeons, general practitioners, nurse practitioners, and nurses. All but three of the articles are composed of quantitative studies of elective breast augmentation and reduction.³⁰ The data set comprises original quantitative studies (survey- and questionnaire-based), articles that present contributions to technique, meta-analyses and literature reviews that reflect the growing clinical interest in patient outcomes and experiences as well as practitioners' increased sense of the importance of pre-operatively and post-operatively assessing their patients' concerns and experiences. I will discuss four, intersecting discursive themes, which, together, produce a narrative about women's engagement with elective breast surgery: the "breasts as individually and socially significant" discourse; the "body image dissatisfaction" discourse, the "motivation for surgery" discourse and the "surgery as transformative" discourse.

Breasts as Individually and Socially Significant

Many of these articles and studies, in their discussions or analyses of breast augmentation and/or breast reduction surgeries, acknowledge and consider the significance of the part of the body on which these surgical interventions are carried out. Many authors make a distinction between surgery carried out on the female breast from surgery carried out on, say, an internal organ—the authors maintain that the female breasts carry a personal and social significance distinct from that of other body parts. In focusing on patient experience and outcomes in the context of breast augmentation or breast reduction, the articles and studies collected discuss the significance of female breasts at the personal, socio-cultural, and/or historical level. Several of these publications acknowledge, in varying ways, the cultural meaning and value of the breasts, and identify connections between social and cultural forces and female body image in the context

³⁰ The three articles in question are qualitative, interview-based studies of women's experiences of elective breast surgery.

of breast reduction and breast augmentation surgeries. The articles and studies suggest that ideas and ideals about female breasts inform women's perceptions of their own breasts, that breasts are an intrinsic aspect of female identity, and that a woman's relationship with and feelings towards her breasts are shaped by social forces like peers and popular media.

First, many of the articles suggest that, in the Western cultural context, there is a commonly held idea about what makes the female body and breasts attractive. Women develop an understanding of what counts as "acceptable" in terms of appearance because they "compare themselves to a cultural idea of beauty" (Figueroa-Haas 2009, 377; Howerton et al. 2011, 95). Several of the articles maintain that there is an "ideal female figure," and they outline the components of this ideal in relation to women's breasts. For example, one article indicates that the "ideal female figure...depict[s] the female breasts as firm, conical projections from the chest wall" (Reich 1974, 772). Articles like these acknowledge that there is a social standard "for an acceptable female figure" that has "varied throughout the ages" but nonetheless remains highly influential (Reich 1974, 772). A woman's relationship to her breasts is said to be influenced by social and cultural discourses about female breasts. "Modern American society," begins one study about breast reduction patients, "sends many messages to young women about the ideal breast and body" (S. Baker et al. 2001, 517). Starting in the mid- to late-20th century, a "change in the fashion of dress" toward form-fitting and increasingly revealing clothing has "drawn further attention to breast size and contour" (J. Baker et al. 1974, 652) because it has made the body more visible and thus more open to examination and scrutiny (Reich 1974, 772). With these changes came the idea that large breasts are more desirable both to men and in society-at-large; women accept these ideals and aspire to fulfil them. Indeed, one study states that "the fuller the woman's bosom, the sexier and more womanly she feels," but its authors recognize

that the link between large breasts and womanliness is a “cultural expectation” (Howerton et al. 2011, 95, 98). A shift in body ideals has changed the basis on which breast size is judged as (in)adequate (Birtchnell et al. 1990, 509). Women undertake breast augmentation or reduction surgery in part because they are motivated by “a conscious desire to conform to current standards of physical attractiveness” (Reich 1974, 773). Yet, despite the social significance and cultural symbolism of breasts, women who are “breast conscious” are positioned, in the broader social context, as “vain, “self-centered, and shallow” (Goin and Goin 1982, 347).

Second, many of the articles and studies indicate that female breasts are significant to women beyond their adherence, or lack thereof, to contemporary appearance norms. According to many of these articles, a woman’s breasts are intrinsically significant to her at the intersection of her identity as a woman, her sense of self in general, and her understanding of herself as beautiful. Physical appearance is positioned in one study as “a central part of female identity” (Didie and Sarwer 2003, 242). Elaborating upon this, an aesthetic surgery nurse writes that “breast size is an important part of feeling good, desirable and normal” (Figueroa-Haas 2009, 377). “Physical beauty” writes one team of aesthetic surgery practitioners, “influences our being, our social life, our behavior and our nature” and if women do not see their breasts as beautiful they will not see themselves as beautiful (Papadopoulos et al. 2014, 480). Several studies and articles point to the “special significance” of the breasts in Western culture as an aspect of female identity that extends beyond its relationship to beauty (Goin et al. 1977; Guthrie et al. 1998; Howerton et al. 2011; Tykkä et al. 2001). One study indicates that “the size and shape of the woman’s breasts are extremely important to...her concept of self” (J. Baker et al. 1974, 652). Other researchers find that “the symbolic function of the breast” predates Western societies (Birtchnell et al. 1990, 509). Nonetheless, “the breasts,” states an early article on breast

augmentation outcomes, “afford the only real external evidence of femaleness” and this is why they are so significant to women and to Western culture (Reich 1974, 773). Along these lines, several of the articles identify the female breasts as having both erotic and reproductive significance, both for women personally and in the social context. One study suggests that “the symbolic function of the breast” is “well known” and represents a woman’s “femininity, sensuality, fertility, and ability to nurture” (Losee et al. 1997, 445). Others make similar assertions: the breasts “[represent] a woman’s femininity, sensuality, and fertility” (Rohrich et al. 2007, 401); they symbolize “sexuality and motherhood” (Guthrie et al. 1998, 331; Goin 1983); and, they indicate a woman’s “ability to nurture” (Birtchnell et al. 1990, 509). With regard to motherhood in particular, one article maintains that the female breast is as important as it is because it “has evolved to provide the perfect nutrition to our newborns” (S. Baker et al. 2001, 517). One article maintains that “psychologically...the breast is important [for women] because of its role in sexual identification and motherhood” (Reich 1974, 773). The breast is also said to have “religious importance” (S. Baker et al. 2001, 517). Because of these multiple, intersecting, and conflicting meanings and representations, women are said to have a “symbolic connection” to their breasts, in which the breasts have a profound influence on how women feel about themselves and how they feel they are perceived by others.

Third, several of these studies and articles consider the relationship between media representations of female bodies and women’s individual perceptions of their bodies. Here, the articles emphasize how media representations of women impact how women understand and relate to their breasts and bodies. Popular media, as is asserted by one study, promotes the idea that “the well-endowed woman is the most desirable” (J. Baker et al. 1974, 652). A study tracing suicide risk in breast augmentation patients suggests that the overvaluation of female breasts

originates in mass media, particularly in the way that the female breast “frequently plays a prominent role in movies, fashion, and advertising, demonstrating its relative value in female perception by society” (Rohrich et al. 2007, 401). Another study, which gives recommendations for how nurses should assess breast augmentation patients, indicates that the “American woman’s breast is closely linked to womanhood” due in particular to its prevalence in mass media, which is a highly influential force in identity formation (Howerton et al. 2011, 95). The mass media promotes to the public-at-large that large breastedness is preferred (Didie and Sarwer 2003, 250). Women first internalize these ideals as appropriate measures for themselves and then work to attain these ideals (Frederick et al. 2008). It is also important to note that several of the articles and studies point out that the media—first in the form of television and film and later in the form of the internet—remains the primary source of information for patients not only about bodily ideals but also the availability of breast augmentation and reduction surgeries (Armstrong and Jones 2000; Crerand et al. 2007; Didie and Sarwer 2003; Frederick et al. 2008; Glatt et al. 1999, 81; Goin 1983; Tykkä et al. 2001).

Body Image Dissatisfaction

Across this literature, a connection is established between body image dissatisfaction and breasted experience. Based on their acknowledgement of the significance of breasts to female identity, the articles subsequently assert that a woman’s dissatisfaction with her breasts can provoke problems with her body image (Howerton et al. 2011, 96). Put another way, dislike of the breasts can generate body image “distortion,” wherein women, when assessed pre-operatively, will express a disunity between their internal perception of their physical appearance and the reality of their physical appearance (Brown et al. 1999). It can also provoke women to develop “body image dissatisfaction,” in which they express a pre-operative dislike of their

entire body due to severe discomfort with one body part (Howerton et al. 2011, 95). Although there exist definitional differences, no distinction is maintained between body image dissatisfaction, body image distortion, and body dissatisfaction; they are treated as one and the same phenomenon and experience.³¹ The discomfort that the dislike of a certain body part provokes is reportedly common in women seeking breast augmentation *and* breast reduction (Riggio et al. 2008). In this respect, “reconstructive patients are not so psychologically different from cosmetic patients” (Riggio et al. 2008, 135) but they remain distinct from control groups who are not seeking surgery in that surgical patients have poorer body image scores (Cook et al. 2006; Guthrie et al. 1998). Some of the studies offer precise definitions of body image dissatisfaction and work to establish the relationship between a woman’s discontent with her breasts and overall body image dissatisfaction, whereas others focus on the symptoms and physical and psychological consequences of body image dissatisfaction.

When body image dissatisfaction is defined in and by this literature, it is typically presented as a negative relationship that a woman has to her body in terms of physical appearance. Where breasts are concerned, women are said to develop body image dissatisfaction when they perceive their breasts to be too big, too small or too droopy (Frederick et al. 2008). One study by a plastic surgery nurse states that a woman’s body image “can negatively be affected by her perception that her breasts are either too small or too large” (Gladfelter 2007, 136). One set of authors defines body image dissatisfaction as “negative perceptions, thoughts, feelings, and behaviors a woman has about her body” (Sarwer et al. 2007; Sarwer et al. 2007 cited in Howerton et al. 2011, 96). Several of the studies and articles focus more precisely on the origins of body image dissatisfaction. Body image dissatisfaction is estimated to arise from a

³¹ Feminist studies on body image have identified a similar terminological and conceptual slippage (Gleeson and Frith 2006; Markula 2001).

“heightened dissatisfaction” and “preoccupation” with the size and/or shape of one specific feature of the body, which may lead to dissatisfaction and problems with the body as a whole (Didie and Sarwer 2003; Kellett et al. 2008). One study, which investigated post-operative outcomes for aesthetic surgery patients, including breast augmentation patients, indicated that body image dissatisfaction “arises in the cosmetic surgery patient” when she “internalizes the appearance and dislike of the body part [which produces] a subsystem of psychological discomfort” (Rankin et al. 1998, 2139). A study that surveyed women about their relationship with their breasts finds that, overall, “breast dissatisfaction may be an important factor that contributes to overall body dissatisfaction” (Frederick et al. 2008, 209). More concretely, Figueroa-Haas’s (2009) review of the literature on psychological issues in breast augmentation reveals that the dislike of the breasts produces, in pre-operative patients, an overall sense of bodily dissatisfaction; she writes that “lower breast size satisfaction was associated with lower body satisfaction” (378).

The majority of the articles that discuss body image dissatisfaction focus on both its prevalence and its negative consequences for women who, in this case, are pre-operative breast augmentation and breast reduction patients. Many studies and articles communicate this finding in both breast reduction and breast augmentation patients, pointing out that body image dissatisfaction is a cause for concern among health care practitioners. One study of pre-operative breast reduction patients states that “excess breast size can cause significant physical, social and psychological problems” (Mazzocchi et al. 2012, 1311). An article promoting a new technique for breast reduction surgery indicates that “large, heavy, pendulous breasts can be the source of significant difficulties” (Hagerty and Uflacker 2009, 401). As a result of these difficulties, the authors continue, “many patients with large breasts have a poor body image” (Hagerty and

Uflacker 2009, 401). Along these lines, a study of breast reduction patients with bulimia indicates that “macromastia has been well known to cause a distorted body image” (Losee et al. 1997, 445) while a study of the psychological and physical effects of breast reduction suggests that “women affected by macromastia are frequently dissatisfied with their body image” (Rogliani et al. 2009, 1649). Women who have breast “disorders” such as “gigantomastia” or “tuberous breasts” are said to be more likely to see “marked effects on...[their] body image, self-esteem and social adjustment” (S. Baker et al. 2001). The literature indicates that such “difficulties” are also applicable to and common among breast augmentation patients. “Body image dissatisfaction,” write the authors of a literature review about the relationship between breast augmentation and mortality, “is common among women seeking breast augmentation” (Lipworth and McLaughlin 2010, 236). A study of breast augmentation patients that examines their suicide risk indicates unequivocally that these women “are body-dissatisfied” (Joiner 2003, 371) while a different study of breast augmentation patients’ motivations found that women did not display body image dissatisfaction as per questionnaire results, just dissatisfaction with a particular feature (Didie and Sarwer 2003, 249-50).

Many of the studies that focus specifically on motivations for and/or outcomes of surgery identify specific consequences of body image dissatisfaction for their female patients. The effects and/or symptoms of body image dissatisfaction are stated over and over again in this subset of the literature. First, large-breastedness, which is also called macromastia or gigantomastia, can cause an “array of physical symptoms” (Rogliani et al. 2009, 1647). These include: physical discomfort (Birtchnell et al. 1990; Guthrie et al. 1998; Klassen et al. 1996); back, neck, and shoulder pain (Hagerty and Uflacker 2009; Heddens 2003; Jones and Bain 2000; Klassen et al. 1996; Kreipe et al. 1997; Larson and Gosain 2012; Losee et al. 1997; Piza-Katzer

and Umbricht-Sprüngli 1991; Reich 1974; Rogliani et al. 2009), shoulder grooves and/or scarring from the pressure of bra straps (Guthrie et al. 1998; Hagerty and Uflacker 2009; Jones and Bain 2000; Kreipe et al. 1997; Losee et al. 1997; Piza-Katzer and Umbricht-Sprüngli 1991; Reich 1974; Rogliani et al. 2009), mastodynia (i.e., painful breasts) (Guthrie et al. 1998; Piza-Katzer and Umbricht-Sprüngli 1991; Rogliani et al. 2009) and skin breakdown (e.g., rash, rawness, chafing) (Hagerty and Uflacker 2009; Jones and Bain 2000; Klassen et al. 1996; Kreipe et al. 1997; Larson and Gosain 2012; Losee et al. 1997; Piza-Katzer and Umbricht-Sprüngli 1991). Practically speaking, women who have very large breasts report difficulty buying ready-to-wear clothing (Glatt et al. 1999; Goin et al. 1977; Guthrie et al. 1998; Heddens 2003; Jones and Bain 2000; Klassen et al. 1996; Kreipe et al. 1997; Reich 1974; Rogliani et al. 2009). Although these physical problems are not presented as being produced by body image dissatisfaction, they are recognized as indirectly related to and compounding the psychological problem of body image dissatisfaction. The physical, social, and emotional concerns that breast augmentation and breast reduction patients express “are encompassed by the psychological construct of body image” (Glatt et al. 1999, 76).

Body image dissatisfaction can generate a series of psychological problems. These problems arise in women regardless of whether their body image dissatisfaction is provoked by their perception that their breasts are too large, too small or too droopy. The psychological problems produced by body image dissatisfaction include a range of negative affects and emotions: self-consciousness (S. Baker et al. 2001; Goin et al. 1977; Guthrie et al. 1998; Klassen et al. 1996; Rogliani et al. 2009), embarrassment (Birtchnell et al. 1990; Glatt et al. 1999; Goin et al. 1977; Guthrie et al. 1998; Hagerty and Uflacker 2009; Klassen et al. 1996; Kreipe et al. 1997; Rogliani et al. 2009), and low or poor self-esteem (S. Baker et al. 2001; Figueroa-Haas 2009;

Guthrie et al. 1998; Howerton et al. 2011; Jones and Bain 2000; Klassen et al. 1996; Ohlsén et al. 1978; Rogliani et al. 2009). Women who have body image dissatisfaction in relation to their breasts report feelings of inferiority (Piza-Katzer and Umbricht-Sprüngli 1991) and insecurity (Piza-Katzer and Umbricht-Sprüngli 1991). Women whose body image dissatisfaction arises from their perception that their breasts are too small will express feelings of inadequacy (Howerton et al. 2011; Ohlsén et al. 1978; Riech 1974). Some women express embarrassment and/or shyness because they have been or are ridiculed by others for their “inadequate” breasts (S. Baker et al. 2001; Goin and Goin 1982; Guthrie et al. 1998; Heddens 2003; Larson and Gosain 2012). Body image dissatisfaction imbues women with feelings of “frustration or helplessness” toward their bodies (Rankin et al. 1998, 2143-4). Women with body image dissatisfaction caused by the feeling that their breasts are too large or too small are said to be “vulnerable” (Guthrie et al. 1998; Ohlsén et al. 1978). The articles and studies propose that body image dissatisfaction is a source of concern for patients and practitioners. One study points to a rise in cases reported in the literature of “enormous suffering and unbearable psychological strains,” of which health care professionals and practitioners should be aware (Piza-Katzer and Umbricht-Sprüngli 1991, 47). Body image dissatisfaction has, as many of these articles and studies indicate, significant implications for a woman’s overall mental health and well-being. Women with body image dissatisfaction are “physically very healthy, [but] they [are] mentally unstable” (Ohlsén et al. 1978, 45).

When women become preoccupied with their dissatisfaction with their breasts, whether they perceive them too large or too small, they report a negative impact on their general functioning in the world (Ohlsén et al. 1978; Reich 1974) and their overall quality of life (Piza-Katzer and Umbricht-Sprüngli 1991). More specifically, women with breast-related body image

dissatisfaction will develop certain behaviours and practices that arise directly from their dissatisfaction. Women who feel their breasts are too small will avoid “revealing” clothing (Guthrie et al. 1998) and will avoid being seen undressed (Didie and Sarwer 2003; Ohlsén et al. 1978; Reich 1974). As a result of the latter, they will report difficulties establishing intimate relationships (Guthrie et al. 1998; Ohlsén et al. 1978) or difficulties in their current intimate relationships (Ohlsén et al. 1978; Reich 1974). Body image dissatisfaction can provoke women to withdraw from exercise and/or recreational sports (Glatt et al. 1999; Goin et al. 1977; Guthrie et al. 1998; Hagerty and Uflacker 2009; Heddens 2003; Piza-Katzer and Umbricht-Sprüngli 1991; Reich 1974; Rogliani et al. 2009). It can exacerbate shyness or incite a withdrawal from social activities (Goin et al. 1977; Guthrie et al. 1998; Hagerty and Uflacker 2009; Reich 1974). Women who perceive their breasts as being too large may inadvertently develop poor posture (Birtchnell et al. 1990) or intentionally change their posture to conceal their large breasts (Hagerty and Uflacker 2009; Heddens 2003; Larson and Gosain 2012; Losee et al. 1997; Reich 1974).

In addition to this series of negative affects and modified behaviours, several studies report more severe and serious possibilities that can arise from breast-related body image dissatisfaction. One study indicates that “body image dissatisfaction...is an established risk factor for mood and eating disorders” because women may engage in disordered eating to try to reduce their breast size (Lipworth and McLaughlin 2010, 236; Losee et al. 1997). (Another study of breast reduction patients finds that “although the women were unhappy with their bodies, they did not report abnormal dietary practices to try to alter their body shape” (Guthrie et al. 1998, 338).) A different study agrees with this claim and cites it and other literature that states that body image dissatisfaction “is a risk factor for mood and eating disorders, which, in turn,

represent strong risk factors for suicide” (Lipworth and McLaughlin, cited in Joiner 2003, 374). The results of one research group demonstrate that the problems that body image dissatisfaction generates “often result in a depressive reaction that sometimes can end in suicide” (Ohlsén et al. 1978, 42). According to the literature, body image dissatisfaction produces a range of physical, emotional, psychological and social problems (Klassen et al. 1996). These problems, in turn, motivate women to seek breast augmentation or breast reduction surgery (Gladfelter 2007, 140) specifically because “body image distortions [interfere] with their abilities to function effectively” (Goin and Goin 1982, 195). As one study suggests, “the motivation for seeking surgery [has] its origins in poor and distorted body image rather than in any physical defect” (McIntosh et al. 1994, 151).

Motivation for Surgery

Problems with body image—and the physical and psychological problems this subsequently produces—motivate women to seek, in this instance, breast augmentation or breast reduction surgery (e.g., McIntosh et al. 1994; Sarwer et al. 2007). As one study points out, “one of the consequences...of body image dissatisfaction is the need to change one’s body shape and weight” (Garrusi et al. 2013, 941). Breast augmentation, as another study suggests, “is one of the most commonly performed procedures for women seeking improvement in their body image” (Bogdanov-Berezovsky et al. 2013, 395), while breast reduction can reveal “positive changes in body image and increase in self-esteem in patients” (Borkenhagen et al. 2007, 364).

The need and/or desire and/or motivation to change the body is said to come from internal factors, external factors or a combination of both. Internal motivators are pressures that arise within the woman herself and that influence her decision to undergo surgery (Sarwer et al. 2007). These include a woman’s sense of self, self-esteem, self-confidence, quality of life and

strength of body image (Larson and Gosain 2012), and/or her degree of body dysmorphic disorder (BDD) (Howerton et al. 2011).³² External motivators are those pressures that arise outside of the woman and that generate a desire for surgery (Sarwer et al. 2007). These are “linked to a focus on obtaining the approval of others” (Larson and Gosain 2012, 139e). These include physical attractiveness, pressures from romantic partners, pressures from peers, and occupational requirements (e.g., modeling, sex work) (Howerton et al. 2011). Elizabeth Didie and David Sarwer (2003), in a study of patient motivations, find that, upon surveying prospective patients, there are five factors that influence the decision to have breast reduction or augmentation: intrapsychic factors (related to physical appearance, body image, quality of life); interpersonal factors (importance of the breast in social and intimate relationships); informational factors (degree of awareness of surgery); medical factors (degree of awareness of risks and complications); and economic factors (affordability of surgery).

The studies, articles and literature reviews that comprise the data set emphasize several, specific aspects of these internal and external motivations, but they focus especially on internal motivations, which, as outlined earlier, are related to or intersect with body image. The studies and articles suggest that women seek breast augmentation or reduction in order to “improve” or “enhance” their body image. For instance, one study of breast augmentation patients finds that the “great majority have the surgery primarily to improve their body image” (Cash et al. 2002,

³² A number of the studies and articles emphasize the importance of screening potential breast augmentation and breast reduction patients for Body Dysmorphic Disorder (BDD) (e.g., Crerand et al. 2007; Rohrich et al. 2007; Sarwer et al. 2007; Zuckerman and Abraham, 2008). Drawing on the then-current *DSM-IV*, Figueroa-Haas (2009) defines BDD as “a preoccupation with an imagined defect in appearance” wherein “if a slight physical anomaly is present, the person’s concern is markedly excessive” (379). She goes on to say that, in cases of BDD, “the preoccupation must cause significant impairment in the individual’s life, and the individual thinks about his or her defect for at least an hour per day” (Figueroa-Haas 2009, 379). Patients who enter into surgery with unrealistic expectations are frequently left disappointed with the results of surgery no matter how “good” they might be, aesthetically and functionally speaking (Lipworth and McLaughlin 2010). As a result, many of the articles recommend pre-operatively screening patients for BDD (e.g., Gladfelter 2007; Rohrich et al. 2007). An analysis of the way that this literature mobilizes BDD in this particular context would be an interesting line of inquiry, but because BDD is distinct from body image (and body image dissatisfaction) it is beyond the scope of this project.

2114) while another indicates that a “central motivation for patients to undergo cosmetic surgery is the hope of becoming more satisfied with their own appearance and improving their psychosocial functioning” (von Soest et al. 2009, 1239). Breast augmentation procedures are “generally performed for women seeking to improve their body image” (Bogdanov-Berezovsky et al. 2013, 395). Some studies point to body image in generalized terms that connect it to a woman’s relationship to her sense of self. A study of 3000 breast augmentation patients revealed that 30% reported that they undertook surgery “to improve the way I feel about myself” (Gladfelter and Murphy 2008, 173). In addition, a prospective survey of adolescents that determined their attitudes toward aesthetic surgery reported that, were they to seek aesthetic surgery, “90% said their motivation was to feel better about themselves” (Pearl and Weston 2003, 629), which suggests that to “feel better about oneself” is a motivation sensible to and understood outside of pre- and post-operative populations. Several studies point to women’s interest in improving certain aspects or components of their body image. One study indicates that “patients...sought improvement in self-confidence, self-esteem, and body image” (Kreipe et al. 1997, 179). A study of breast augmentation patients indicates that patients seek surgery “to improve their self-esteem” (Cash et al. 2002, 2114). Self-confidence is stated as a primary motivator in a number of studies. One literature review finds that the majority of patients undertake surgery with the intention of “increasing their self-confidence” and to subsequently enjoy the benefits of “popularity” and “assertiveness” that come with increased self-confidence (Howerton et al. 2011, 96).

Many of the studies indicate that breast augmentation and reduction patients also express concerns with their physical appearance at the level of overall physical attractiveness. An early study of breast augmentation patients indicates that they “wanted to look better and wanted to do

without a padded brassiere” (J. Baker et al. 1974, 655). One study of breast augmentation patients indicate that they undertake the risk of surgery in order “to gain more physical attractiveness” (Papadopolous et al. 2007, 916). A study by Cash et al. (2002) also found that women were motivated to pursue breast augmentation surgery by a desire to improve their “feelings of femininity and sexual attractiveness” (2114). One outcomes study indicated that 50% of patients “have breast implant surgery to make themselves feel better about their physical appearance” (Gladfelter and Murphy 2008, 173). Another study discussed attractiveness in terms of the breasts themselves, indicating that, in addition to “relief of pain and discomfort,” breast reduction patients had “great expectations and hopes for a better appearance of their breasts” (Goin et al. 1977). Several studies affirm that the aesthetic result is very important to breast augmentation and breast reduction patients (Tykkä et al. 2001) while others stress that aesthetics are not as significant as proportion (Botti and Cella 2002; Turhan-Haktanir et al. 2010). For example, one study indicates that the breast augmentation patients surveyed did not want large breasts but rather “well-proportioned, normal-sized breasts” (J. Baker et al. 1974, 655). A subsequent study reports the same finding, indicating that women presenting for either breast augmentation or reduction surgery want “to achieve more normal body proportions” (Kreipe et al. 1997, 177).

Patient motivation for breast augmentation and reduction is presented as predominantly intrinsic. Many of the studies are keen to point out that women seeking breast augmentation and breast reduction are not motivated to do so by the promise of increased attention from their current partner or by the possibility to increase their chances of meeting a new romantic partner(s) (Gladfelter and Murphy 2008). In fact, some studies indicate that, in the case of long-term heterosexual relationships, a woman’s partner was not dissatisfied with her breasts nor was

he encouraging the patient to undergo surgery (Reich 1974). Instead, as one study points out, “the strongest motivation came from the patient; in no case did she desire the surgery to please other persons” (J. Baker et al. 1974, 655). The overarching narrative in this literature is that women who present for elective breast surgery are undertaking surgery “for themselves” (Armstrong and Jones 2000, 480). The peculiarity of this emphasis on intrinsic motivations, considering practitioner awareness of the influence of social and cultural factors on body image issues, will be explored in more detail in the discussion.

Internal motivations are also connected to a woman’s sense of herself as a woman and as feminine. This makes sense given that, as outlined earlier, the literature holds that breasts are in many ways significant to women. In one study, women who were dissatisfied with their breasts but who had also had gynecological complications wanted breast augmentation to ameliorate their “feelings of ‘being less of a woman’” and “restore their feelings of femininity” (J. Baker et al. 1974, 655). Another study reported that over 90% of patients surveyed wanted surgery to “improve their confidence and make them feel more feminine” (Birtchnell et al. 1990, 511). In addition, a study of quality of life outcomes in 40 breast reduction patients indicated that, pain reduction notwithstanding, a primary motivator was the “improvement of body acceptance and physical and psychologic well-being” and a desire to “improve self-confidence,” the “fit of their clothes” and their “lack of femininity” (Borkenhagen 2007, 368). Overall, the articles communicate that breast augmentation and reduction presents, as Joanne Gladfelter (2007) puts it, a “unique opportunity” to accommodate “women’s specific and individual needs...rather than just produce a bra size” (138). Women’s “desire to increase self-confidence and sex appeal” is a primary motivator, she continues, and the best results will be produced in a “patient who is *internally* motivated [and] pursuing surgery for self-satisfaction and often expresses a desire to

look better in clothes and to feel better about herself and her body image” (Gladfelter 2007, 140, emphasis added).

Surgery as Transformative

According to these articles and studies, body image dissatisfaction is remediable with breast augmentation and breast reduction surgery. In the case of empirical studies of patient outcomes, this position is communicated via an appeal to the positive outcomes of these surgical procedures, which is determined by surveying post-operative patients. Where meta-analyses and literature reviews are concerned, this finding is generally reported with reference to or in citations of the literature under examination. This emerges along two interrelated axes: a discussion of specific improvements regarding bodily and/or psychological function and a discussion of the overall change for women in terms of improved body image or body satisfaction.

The positive outcomes of breast augmentation and breast reduction surgery are frequently presented as borne out in and by studies of patient outcomes. Original empirical studies of surgery patients, conducted pre- and/or post-operatively, testify to the “success” rates of surgical procedures in terms of the degree to which breast reduction or breast augmentation can “improve” body image with regard to a change in or the elimination of the specific symptoms outlined earlier. In a recent study of 73 post-operative breast augmentation patients, 71% reported an increase in “their sexuality” while 99% reported an improvement in “their personal well-being” and 84% now choose clothes that are more fitted and/or revealing and newly avoid loose clothing that hides their breasts (Papadopolous et al. 2014, 481). These patients also demonstrated, when compared with extant “norm data,” “a very well balanced emotional stability” in their post-operative existence (Papadopolous et al. 2014, 482). A study of 228

aesthetic surgery patients, also led by Papadopolous, reports that, at both three and six months after surgery, patients “feel healthier and more satisfied with their appearance” (Papadopolous et al. 2007, 919). A small-scale study of seven breast reduction patients who subsequently had breast augmentation found that body image “improved in 100% of patients” (Colwell et al. 2008) while a study of 360 breast augmentation patients reported that “over 90%...were satisfied with their attainment of...the improvement of body image” (Cash et al. 2002, 2119).

There are also many studies that consider the intersection of body image, elective breast surgery, and disordered eating. A small study of six breast reduction patients who struggled with bulimia reported that the patients’ “physical symptoms improved substantially” in terms of back, neck and shoulder pain as well as shoulder grooves (Kreipe et al. 1997, 177). The surgeons also report “profound and long-lasting improvement” in their patients’ disordered eating behaviours and conclude by recommending breast reduction as “beneficial” to but not a “cure” for disordered eating (Kreipe et al. 1997, 180). A different study of breast reduction patients struggling with bulimia indicates that “body satisfaction (with respect to breasts) was significantly increased following surgery” (Losee et al. 1997, 444). A study that followed a group of breast augmentation patients who have soybean-filled implants reports that 82.5% of these patients indicated “enhanced” body image, including greater self-confidence and a feeling of increased sex appeal (Armstrong and Jones 2000, 480). A study of quality of life outcomes for 105 aesthetic surgery patients, which includes breast augmentation patients, reports that surgery can “improve quality of life outcomes” because “subjects reported an overall positive change” within the parameters of social and sex life, leisure activities, and friendships (Rankin et al. 1998, 2141-2). Similar findings are reported for breast reduction patients. A survey of 40 breast reduction patients found “significant improvement of body image satisfaction” with 76% of

patients reporting “an improvement of general well-being and increased body acceptance” and 60% reporting greater self-confidence (Borkenhagen et al. 2007, 368-9). A study of eight breast reduction patients indicates that “early elation” gave way to a “general sense of well-being, increased confidence, and heightened self-esteem.” A survey of 166 breast reduction patients found “great improvement in physical function” with significant improvements in “health status” and a “large change in self-esteem” (Klassen et al. 1996, 456-7). An evaluation of breast reduction patients found, 12 months post-operatively, “a significant improvement in terms of quality of life” (Rogliani et al. 2009, 1649). A case study of an 11-year-old breast reduction patient indicated that her symptoms of “self-consciousness” and “embarrassment” improved and that “postoperative somatic and psychological changes progressed very positively” (Piza-Katzer and Umbricht-Sprüngli 1991, 48). An early, interview-based study of 37 breast augmentation patients reveals that the women “achieved increased self-esteem and a generally improved ability to function: they feel more free and independent and are able to attend to new activities” (Ohlsén et al. 1978, 42). Put another way, because they “seldom [think] of their breasts post-operatively” they are not preoccupied and so have room and energy for productive endeavours (Ohlsén et al. 1978, 49). The authors of this study go on to say that the patients “could now enjoy going swimming, [and] sexual problems were markedly reduced” (Ohlsén et al. 1978, 49). A long-term, multi-centre study of body image in 455 breast augmentation patients reported “significant improvements of feelings of sexual attractiveness” as well as improved self-image, daily living and social relations, and notes that these positive results were “well maintained” six years later (Murphy et al. 2009, 120). A recent study of the postural changes experienced by 52 breast reduction surgery participants indicates that “a new breast eliminates the dissatisfaction with body image, reduces anxiety, and increases self-esteem” and attributes these outcomes to a

combination of improvements in body image and a reduction in the amount of weight resting on the anterior body (Mazzocchi et al. 2012, 1317).

Articles that engage in reviews of the extant literature on breast augmentation and/or reduction also convey that these procedures improve certain symptoms related to problems of body image. One literature review cites reports of breast augmentation patients who show “more positive sexual functioning,” were “more self-confident, more satisfied with their appearance” and who “demonstrated increased psychological well-being profiles” (Rohrich et al. 2007, 402-3). A review of the literature on motivation for breast augmentation, designed to aid nurse practitioners in patient counseling, indicates that “women who obtain breast implants feel more attractive, have a more rewarding sex life, and greater relationship satisfaction” (Howerton et al. 2011, 97). A literature review intended to help nurse practitioners understand breast contouring in the augmentation context states that “results achieved with breast contouring continue to include relief of physical symptoms and significant increases in self-esteem and body image” (Heddens 2003, 118). In what is otherwise a review of the literature, the authors—who are also aesthetic surgeons—state that, in their clinical experience, adolescents who have breast reduction surgery “have uniformly reported postoperative improvement in self-esteem” and are able to “resume sports and other activities in which they had been embarrassed to participate preoperatively” (Larson and Gosain 2012, 138e). One review of surveys of breast reduction patients found that, following surgery, women “wore tight clothes more often,” “had less difficulty purchasing clothing,” and “were happier with their appearance” (Jones and Bain 2001, 61). The articles that review the extant literature also maintain that surgery has an overall positive effect on recipients. One article, which reviews epidemiological mortality studies in order to question the link between breast augmentation and increased mortality, cites several

studies that indicate that “women who receive breast implants tend to report high levels of satisfaction with their surgery and improvements in body image and psychological well-being, including depressive symptoms” (Lipworth and McLaughlin 2010, 236) but its authors caution against taking very seriously these “anecdotal” results.

Finally, the articles gathered draw the conclusion that breast augmentation and breast reduction surgeries are an effective and reasonable solution to the problem of body image dissatisfaction. This conclusion is reached across the data set—in empirical studies, literature reviews and original articles. A survey of breast reduction patients claims that while this procedure is “foremost a functional procedure able to alleviate physical symptoms” it also “increases patients’ satisfaction with their body image and improves their life from both a psychological and relational point of view” (Rogliani et al. 2009, 1649). Another study asserts that breast reduction “restores youthful contour, relieves pain, and improves body image in most women with macromastia” (Colwell et al. 2008, 372). A review of the literature that considers breast reduction in adolescents points out that “multiple studies have showed improved psychological profiles for women following breast reduction, specifically in the areas of body image self-esteem and personal relationships” (Larson and Gosain 2012, 138e). Two studies of bulimic breast reduction patients indicate that the procedure is “beneficial” (Kreipe et al. 1997) and can serve as a “treatment” for the associated eating disorder (Losee et al. 1997, 446). A case study of breast augmentation and reduction patients finds that surgery is reflective of a woman’s “trying to solve a psychological problem—an attitude of mind” which, the author argues, is better served by surgery than reliance on others or drugs (Reich 1974, 774). The author concludes that “aesthetic plastic surgery [both augmentation and reduction] is able to provide a definitive solution to some of these problems [related to body image dissatisfaction]” and

surgeons and health care practitioners should support it because it “provides a valuable therapeutic approach of those who are concerned with the improvement in the quality of life of their patients” (Reich 1974). One study of patients concludes that “cosmetic surgery is an effective treatment that allows individuals to ameliorate self-consciousness about appearance” by engaging in the surgical alteration of “body parts that cause psychological distress” (Rankin et al. 1998, 2142).

The notion that breast augmentation and breast reduction enhance or improve body image is also supported by articles that review and/or evaluate the extant literature. Rohrich et al. (2007) point to the “psychological benefits of breast augmentation as a result of subjective improvement in the patient’s...body image” (403). The authors go on to say that patients report “a significant reduction in the degree of dissatisfaction” (403). Sharon Cook et al. (2006) cite five quality of life surveys that found immediate improvement in patients’ “emotional function, social function and mental health” compared to their pre-operative scores (1137). Overall, their review of 23 reports concludes that, among aesthetic procedures, breast reduction surgery in particular “improves health-related quality of life” (2006, 1138). One article intended to teach nurses about their role in patient care during breast augmentation surgeries argues that, in the author’s professional experience, breast augmentation “enable[s] women to enhance and reshape the normal structure of the breast to improve appearance and alter body image” (Glatfelter 2004, 137). A recent study of breast augmentation patients “proved” that “breast augmentation significantly improved our patients’ QOL [quality of life] in general and their ‘body image’ perception” and that “breast augmentation has a direct, positive impact both in patients’ self-esteem and sexuality [producing]...uplifted mood” (Papadopolous et al. 2014, 485). In a general study of aesthetic surgery patients, the same lead author found that surgery produces

improvements in overall quality of life (Papadopolous et al. 2007). A study of body image in a large population of breast reduction patients operated on over a period of 14 years concludes that “this procedure also leads to a significant decrease in body image dissatisfaction” (Glatt et al. 1999, 81). A technical article promoting the “central mound technique” for breast reduction procedures indicates that “many patients with large breasts have poor body image” but suggests that “reduction mammoplasty can eliminate the symptoms and reduce the psychological distress,” which is the “goal” of this procedure (Hagerty and Uflacker 2009, 401). Lastly, one study that explores the relationship between aesthetic surgery and suicide draws on previously published quantitative data to rationalize that because breast augmentation offers a “protective [effect] of increased body image satisfaction” it diminishes the “mental disorders that predispose people to suicide” (Joiner 2003, 374). The articles are overwhelmingly positive in their evaluation of the post-operative effects of breast augmentation and reduction. This is the case both across the data set—literature reviews, patient satisfaction surveys and reports on technique—and over the 40 years in which the data were published.

It is important to address that very few of these studies, reviews, and articles report negative findings, neutral findings, or call into question the positive benefits and outcomes that they indicate in cases of breast reduction and augmentation. When negative findings are reported, they are presented as idiosyncratic case studies or as temporary setbacks for patients that are remedied over time. One in-depth case study of a white, 37-year-old recipient of breast reduction reports that she experienced body image distortion *after* her surgery. The authors, both psychiatrists, identify a range of explanations, including the change in bodily orientation, a newfound sense of imbalance, and/or diminished bodily sensation. They report that the body image distortion was short-lived and that the post-operative body image came to feel “right” for

the patient and in turn “improved [her] relationships” and “bolstered [her] self-esteem” (Goin and Goin 1982, 195-196). Another case study, this time sole-authored by Marcia Goin (1982), also suggests that body image problems can develop after surgery, and indicates that it takes some time for a patient’s perception to “catch up” with their new material reality. A separate study led by Marcia Goin indicates that some breast reduction patients experienced, despite their prior dissatisfaction with their breasts, an initial sense of loss and grief post-operatively, but that this was remedied over time once the new breast was fully “incorporated” into the body image (Goin et al. 1977, 533). Here, the authors recommend preparing patients for this sense of loss and period of adjustment (Goin et al. 1977, 534). Only one of the articles questions the appropriateness of performing elective breast surgery on women who present with problems of body image or body dissatisfaction. The authors raise the possibility that “psychological treatment, either of an interpersonal or cognitive form, could be a possible alternative to surgery for some women” (Guthrie et al. 1998, 339). Only one article in the data set questions the many positive effects and overwhelmingly positive results of breast augmentation surgery (Cook et al. 2006). The authors wonder whether the positive outcomes are the operation of cognitive dissonance wherein patients changed their attitudes to fit their decision, but, in conducting a meta-analysis, they recognize that they could not pursue this line of inquiry (Cook et al. 2006, 1149). (There are researchers who evaluate the measures used in and results obtained by patient satisfaction surveys along the lines of cognitive dissonance, and suggest that, when surveyed post-operatively, patients “tend to provide a positive outcome evaluation to justify their own behavior” (Moss and Harris 2009, 568). There have also been attempts to produce evaluation measures that reduce the possibility of cognitive dissonance (Byrne 2016; Homer et al. 2000).)

Whether the publication is a post-operative patient satisfaction survey, a pre-operative assessment of patient motivations, a case study, a meta-analysis, a literature review, an exploration of a new technique, or a position paper, the clinical literature on breast augmentation and reduction collected in this data set is consistent in its endorsement of breast augmentation and breast reduction surgeries in terms of surgeons' capacity to meet patients' "specific and individual needs" (Gladfelter 2007, 138). The articles maintain that not only are women motivated to undertake one of these procedures in order to "improve" or "enhance" body image—both in general and to the extent that body image problems generate a number of symptoms—they also affirm that these procedures can and will accomplish this objective. The articles communicate a specific narrative of breast augmentation and reduction, which indicates that because the breast is significant to a woman's identity and sense of herself as desirable and "normal," dissatisfaction with the breasts can cause broader problems with body image. This dissatisfaction can become so powerful that women are motivated to change their bodies through surgery; fortunately, surgery can assuage or eliminate these concerns. In the next section, I interrogate the effects and implications of this narrative, with emphasis on how the concept of body image is leveraged to identify and manage deviations of the body *and* body image. These deviations are conceptualized as pathological and offered up for regularization via the transformative potential of surgical intervention.

Normalizing Effects of Body Image in Clinical Discourses on Elective Breast Surgery

Discourses of Body Image in Clinical Publications

The body image discourse that is presented in clinical publications on breast augmentation and breast reduction surgery produces, alongside these procedures themselves, a

range of normalizing effects. These effects are undergirded by the dominant understanding of body image, which informs how surgeons understand and communicate the significance and impact of breast augmentation and reduction procedures for patients. The way that women's bodies and well-being are cared for in this context is also influenced by the dominant articulation of body image in that the production of healthy body image is supported by reinforcing the pathologization of both body image and bodily diversity producing homogenization across these two axes. The reliance on the mainstreamed notion of body image facilitates the perpetuation and propagation of a discourse of elective breast surgery that states that elective breast surgery can have a transformative effect on body image and produce in individuals a positive/healthy body image that results in subjects who demonstrate a positive disposition and attitude towards their body and, consequently, social life.

The dominant conceptualization of body image, described in the previous chapter, is accepted here as valid, accurate, and legitimate; its legitimacy is reinforced in and by the application of the concept within this literature in the way it is used in evaluations of post-operative outcomes. The articles and studies that do define body image acknowledge that it is an aspect of an individual's psychology interconnected with and influencing a wide range of qualities including self-confidence, self-esteem, self-perception, emotional function, behaviour, and mental health. Those articles and studies that offer precise definitions of body image, while infrequent, rely on the popularized definition of the concept that suggests that it is an internal picture of the body formed by an individual (Gladfelter 2007; Goin and Goin 1982; Goin 1977; Larson and Gosain 2012). Other articles and studies recognize body image as a person's feelings and attitudes toward the body in terms of its size and shape (Garrusi et al. 2013; Kreipe et al. 1997; Mazzocchi et al. 2012). The studies and articles collected here agree and affirm that body

image involves, to a great extent, the degree of satisfaction that women in particular have with their physical appearance.

Although many of these articles are grounded in original, empirical studies of patient motivations, outcomes, and satisfaction in terms of body image, none attempts to challenge or test the validity of this definition of body image, either prior to presenting or through their studies. As a result, the preference for healthy body image as well as the understanding of what this means is arrived at without a critical examination or evaluation of the multiple contextual factors that converge to produce a particular body image as healthy, and without considering how body image and breast image get collapsed in this process of idealization. The dominant definition of body image functions as a grounding concept, and is both uncritically accepted and wholly unchallenged in and by the practitioners who conduct these studies and produce this literature. As a result, they tell and/or reproduce a particular discourse about women's bodies and female body image. The concept of body image that informs these studies and articles mobilizes certain ideas about women's relationships with their bodies and how that relationship is to be understood in the context of elective breast surgery.

The Individualization of Body Image

Because these studies uncritically accept the validity and legitimacy of the dominant model of body image, they have no choice but to locate the problem of negative body image or body image dissatisfaction within the individual. The individualization of body image and body image dissatisfaction means that a woman's expressed interest in or decision to undergo surgery must be framed as internally generated, almost always determined independently of the social context. The articles and studies in the data set reinforce the significance of choice as both the intrinsic motivator for elective breast surgery and a key factor that shapes the post-operative

outcome. Here, women's needs are "specific" and "individual" and surgeons are encouraged to personalize care so as to meet the unique desires of each patient (Gladfelter 2007, 138). Over and over again, we are told that female patients "choose" breast reduction or augmentation surgery "for themselves" as a way to "improve" or "enhance" not the *body*, but the *body image* (Armstrong and Jones 2000; J. Baker et al. 1974; Bogdanov-Berezovsky 2013; Cash et al. 2002; Gladfelter and Murphy 2008; Reich 1974; von Soest et al. 2009). When "body image," understood in its popular sense and becomes the target of surgical intervention, women are "choosing" to change not just their bodies but also their selves via a shift in their psychological disposition. It is here that the emphasis on women's intrinsic motivations for surgery emerges as particularly curious. Although the articles and studies consistently acknowledge that cultural factors and social norms are important in shaping women's individual attitudes towards their bodies and breasts, this acknowledgement of and interest in the social context disappears almost entirely when practitioners begin to consider a woman's motivation for elective surgery. Even though body image dissatisfaction is understood to be pervasive in industrialized societies and, especially influenced by unrealistic body ideals, it is individualized and, in turn, the solution lies within the realm of individual choice (Crawford 1980; Markula 2001). One effect of this individualization is that so long as the attention of women with body image problems remains turned inward, the structures that perpetuate body ideals remain intact (Markula 2001).

Repeatedly, the literature maintains that healthy body image is favourable and that, by contrast, body image dissatisfaction is unfavourable. At the level of the individual, body image satisfaction is the positive and preferable disposition, and body image dissatisfaction is the personally and socially problematic disposition that in turn determines women's pre-operative demeanor and behaviour. This means that a positive attitude towards, perception of, and thoughts

about the body is healthy and desirable. Body image dissatisfaction thus emerges as or is rendered “pathological” because the associated disposition and tendencies that come to be associated with it are understood to have negative connotations and implications for individual well-being. These include, as is articulated in the literature and cited earlier: having low self-esteem and/or self-confidence, feeling unattractive and/or lonely, and withdrawing from social life. We are also told that problems with body image can, at worst, lead to ill mental health and destructive behaviour. Destructive behaviours, such as eating disorders and self-harm, are presented in the literature as detrimental to the individual’s well-being and it is this disposition and these behaviours that subsequently become a target of surgical intervention.

Pathologizing Breast Diversity and Generating the “Need” for Surgical Intervention

Given that the literature enforces the preference for healthy body image and perpetuates the notion that surgical intervention can produce healthy body image, it is evident that the concept of body image is mobilized in a particular way that unequivocally influences how women’s bodies and well-being are taken up and cared for in the elective surgical context. The clinical literature on breast augmentation and breast reduction is concerned with not only identifying women’s body image problems but also with demonstrating that surgery can ameliorate or eliminate the symptoms of poor body image. Medical evaluation and scrutiny of patients’ breasts and body image problems become crucial in determining both the severity of “problems” and the “need” for surgery. Women’s expressed body image problems justify processes of observation that insert women into the processes and procedures of surgical care with respect to both morphology and psychology. The act of observing and recording the presence and prevalence of breast “deformities” and then producing peer-reviewed literature that confirms the “truth” of those “deformities” and their effects converts the individual

woman/patient into a “case” whose concerns about her body and in turn her body image issues are legitimate. As medical cases, women’s experiences are turned into objects of study and examination that generate the creation of the categories and “statistically normal” averages that establish the basis for surgical intervention. Specifically, many of the studies that examine patient motivation and/or outcomes often present pre-operative patient evaluations as “evidence” of the “need” for surgery.

Typically, patients present for surgery and express their concerns and/or complaints about their breasts; these self-evaluations are converted, through the process of “expert” evaluation, into “deviations” that are subsequently leveraged to justify both body image issues and “corrective” surgical intervention. Although, as outlined earlier, many of the articles and studies acknowledge that the culturally constructed standards of female beauty and appearance create for women a “tremendous pressure” to look a certain way (Frederick et al. 2008, 200), these studies and articles retain the notion that there exists nonetheless a “statistically normal” course of female breast development. Female breasts, according to this narrative, develop gradually over the course of adolescence and reach their fullest state in early adulthood, when they become symmetrical, perky, full, and moderate in size (S. Baker et al. 2001; Birtchnell et al. 1990; Larson and Gosain 2012; Ohlsén et al. 1978; Reich 1974). This narrative of development contains within it a broader idea that there is a “normal” breast shape and size in relation to a woman’s age, size, and body type. These studies also retain the notion that there is a “statistically normal” bodily *proportion* for adult women, in that a woman’s breasts should be of a size that is appropriate to her frame (Kreipe et al. 1997). Only one study considers the function of “normal” in the discussion of breast size, but then attempts to quantitatively produce a measure of the “statistically normal” breast (Brown et al. 1999). The authors publishing the studies and articles

gathered here—and who, it is important to point out, are also the health care practitioners that either conduct these procedures or assist in the surgical setting—hold onto socially and aesthetically constructed ideas of what constitutes “normal” breasts as an objective measurement and presented these as the expression of what is average in terms of female morphology and physiology. Because aesthetic surgeons are assumed to be knowledgeable “experts of bodily improvement” (Rose 2007, 20), women trust surgeons to better align their morphology and/or appearance with what is within the realm of acceptability and “normality” (e.g., Balsamo 1992; Blum 2003; Morgan 1991; Shapiro 2015).

Further to enforcing that positive body image is the norm, the clinical discourse on elective breast surgery determines the procedures that establish consensus about which norms prevail and fabricates bodies that adhere to these norms. This physical standard is thus the standard that reinforces the model against which surgeons measure, evaluate, and judge the breasts of women who present themselves for breast augmentation or reduction. Because the body is, both here and in medicine in general, imagined as a temporal entity that passes through processual stages at established times, the body is easily conceptualized in this context as observable and measurable against those processes and targetable upon its failure to comply. Against this preference/standard, all aspects of the breast including size, shape, fullness, perkiness, (a)symmetry, and (in)consistency are scrutinized by surgeons and leveraged to validate requests for surgery and surgical intervention. Any deviations from the aforementioned “statistically normal” course of development become potential “conditions” that women can have surgically “corrected” so as to be in accordance with what is aesthetically and functionally “normal.” In the pre-operative phase, breast diversity is rhetorically repackaged as deformity and abnormality, producing conditions such as lateral or deep ptosis (Brown et al. 1999; Khazanchi

et al. 2006), hypertrophy (of the nipple or breast) (Mazzocchi et al. 2012; Reavey et al. 2011), asymmetry (Brown et al. 1999; Shokrollahi et al. 2010), and tubular or tuberous breast deformity (Jordan and Corcoran 2013). The “normal” position and aesthetic expression of the breasts may be affected by complicating deformities such as pectus excavatum (chest wall deformity) (Quoc et al. 2013) or Poland syndrome (Jordan and Corcoran 2013). Women whose breasts are evaluated as too small are diagnosed with “micromastia,” while women whose breasts are evaluated as too large suffer from “gigantomastia” or “macromastia.”³³ Aside from asymmetry, such “deformities” initially appear as fabrications and/or as jargon, but, in the clinical encounter between patient and surgeon, professional tools and techniques—including palpation, gazing, touching, squeezing, and measuring—function to bring bodily “abnormalities” and “flaws” “to life” and in turn make surgery a desirable option because the individual now has a real, medical condition (Mirivel 2008, 158). Many of the studies contained in the present analysis also support the pre-operative measurement and clinical evaluation of patients’ breasts with a view towards optimal aesthetic results (e.g., Brown et al. 1999; Rogliani et al. 1999). The identification and subsequent legitimization of body image “distortion,” “dissatisfaction” and/or “problems” as generated by breasts that are the wrong size, shape or appearance—and the surgical correction of these problems—indicates that this literature disciplines female breasts towards the discipline of female body image. The way that body image is taken up in this literature is one that first produces as legitimate the negative psychological disposition generated by the body’s “problems,” and second recommends a surgical/medical solution to this negativity.

³³ It is important to acknowledge that the too-large male breast is also pathologized, given the label “gynecomastia,” and recommended for surgical intervention (Papadopolous et al. 2007; da Cunha et al. 2009).

Improved Body Image via Surgical Discipline

Surgical intervention conducted in the name of body image functions to produce or reinstate the capacities that are afforded when the individual fits the norm of “healthy” body image. Problems with body image are, as noted, problems of the individual, and even though the intervention occurs at the level of the body, it is understood, represented and defended as a psychological intervention. A healthy body image is mobilized as the conduit through which one can be galvanized into a state of health but also a state of productivity. Breast reduction and augmentation surgeries are carried out to restore the subject to a state in which they demonstrate a “positive” bodily and psychological attitude. The project of enhancing or improving body image welcomes health care practitioners’ participation in the reinstallation and re-inculcation of individuals into the realm of “well-being”—bringing individual women back into the realm of good psychological health. When conducted for the sake of female body image, the espoused psychological effect of these procedures is the restoration of the self-esteem of the subject such that they will be restored to a state of vitality that generates interest as well as participation in society as productive and engaged individuals. The concept of body image is mobilized in a manner that justifies surgical interventions that not only produce bodies that adhere to aesthetic/medical norms but also individuals that comply with attitudinal norms. In turn, the surgical management of disposition or attitude is, in its intended effects, the management of bodily conduct and behaviour.

“Body image,” in the way that it is understood, evaluated and leveraged by health care practitioners in their publications—and, by extension, in their practice—reveals that breast augmentation and breast reduction surgeries are interventions at the level of conduct. The literature emphasizes as its primary outcome the “favourable” and “positive” results that women

experience in terms of their bodily orientation, lifestyle, attitude, posture, habits, behaviour, disposition, and attention. It indicates, on the whole, that women who undergo elective breast surgery have, to recapitulate from a publication cited earlier, “improved” posture, “healthier” eating habits, and a reduced preoccupation with their breasts (Ohlsén et al. 1978). In turn, their mental energy shifts away from their preoccupation with their body and toward greater participation and productivity in society. In this case, elective surgery endorses “a form of change that will allow the subject to embody social expectations” (Weber 2005, para. 52). By encouraging compliance with common standards of well-being and self-confidence at the level of attention, a significant effect of breast reduction and augmentation is the generation of norms of temperament and disposition that produce appropriate social conduct.

A positive body image is tantamount to body image satisfaction, which is the appropriate attitude and relationship one ought to have toward the body. Understood in this way, body image becomes an individualized phenomenon experienced in isolation of the social and cultural context; the individualization of body image necessarily leads to the individualization of body image problems. Medical experts, although they acknowledge the role of cultural stereotypes in the production of aesthetic ideals that influence individual bodily perceptions, nonetheless advocate for modifying individual behaviour and morphology such that it responds to cultural stereotypes (instead of advocating the abolishment of those very stereotypes). Upholding the notion of individual perception or correlation as the measure of positive body image enables the observation and classification of women’s attitudes towards their bodies as well as the organization of those attitudes into categories of “normal” and “pathological,” despite the aforementioned recognition by some of these articles and studies that women’s concerns and motivations for surgery develop in a social context that has long generated for them unrealistic

aesthetic expectations. This process parallels the demarcation of “normal” and “abnormal” breast development. In this way, body image is a measurement of perception that allies coherence of perception with positivity and thus produces positive body image as the standard.

The fact that the popularized notion of body image—including body image problems and symptoms of poor body image—is so prevalent in how health care practitioners understand the intention and presumed outcomes of elective breast reduction and augmentation surgeries suggests that body image functions as a regulatory mechanism for the development of a “healthy” or “normal” bodily disposition and conduct in compliance with extant norms of productivity and well-being. The concept of “body image” functions to produce a normalizing effect that not only legitimizes the establishment of the breasts as an object for surgical intervention towards the production of homogenous bodies but also generates behavioural and attitudinal standards that regulate and dictate how women ought to relate to and with their bodies and body parts. The authors of these studies invite women to participate in this regulation through an appeal, in their emphasis on women’s intrinsic and personal motivations, to discourses of choice and individuality. The dominant conceptualization of body image works, in this literature and, by extension, in the context of elective breast surgeries as a form of social power.

In the context of elective breast surgery, then, the dominant understanding of body image becomes a norm that determines and expresses the procedure for enforcing attitudinal and behavioural preferences. The survey mechanisms that measure and track the motivations of either current or prospective patients make explicit use of the self-reported judgments of self-esteem, self-confidence, anxiety, level of activity and involvement in interpersonal, romantic, and sexual relationships, and quality of life. In tracking women’s motivations for requesting

elective breast surgery, practitioner surveys and questionnaires function as a mechanism of observation and calculation that first leverages “body image satisfaction” as a developmental norm and second enables the calculation of deviations in the form of body image dissatisfaction. These oppositions are played against one another in the calculation or presentation of evidence of deviation, which allows practitioners, whether psychologists, nurses or surgeons, to justify the intervention of its institutions to both deal with and manage this “problem” of body image dissatisfaction through the bodily discipline of surgery.

The Transformative Potential of Elective Breast Surgery

As uncovered in the presentation of the findings, this literature demonstrates that negative or poor body image can be transformed by elective breast surgery. Women who exhibit the negative disposition and characteristics that, according to this literature, express body image dissatisfaction and lead to destructive behaviours are not excluded from the realm of the normal by virtue of their deviance; instead, they are invited to participate in remedial surgical intervention for the purposes of transformation and reinvention (Taylor 2009). Because, in this literature, women are presented as experiencing tangible “suffering”—manifested as the many symptoms of negative body image cited earlier—they are seen as presenting for surgery with the “right desire” (Weber 2005). As per the clinical literature, the psychic suffering caused by negative body image exceeds physical pain, and so the true transformation offered by breast augmentation and breast reduction occurs at the levels of self-esteem, well-being, self-confidence, and sexual pleasure. This is a surface or “outside-in” transformation of psychological attitude that is executed at the level of appearance; this approach is all that can be offered by surgeons in working within the “market model” of medicine (Hurst 2009; Weber 2005). The discourse of elective breast surgery includes “problematic” body image as that which can be

transformed by surgical intervention on the bodily exterior. The overwhelmingly positive evaluation of the transformative impact of the results of breast augmentation and breast reduction—self-reported by patients and compiled in the literature in the form of statistics—are compared to their pre-operative attitudes in order to establish that elective breast surgery has a positive and transformative impact on women with breast-related body image dissatisfaction or distortion. The transformative potential of elective breast surgery is so entrenched that elective breast surgery has actually been promoted as “body image surgery” (Pruzinsky and Edgerton 1990) and as “surgery for the psyche” (Hollyman et al. 1986). Clinical discourses of breast reduction and augmentation understand and represent breast-related body image dissatisfaction as a legitimate medical problem for which breast augmentation or reduction surgery can offer the greatest and most appropriate relief.

In addition, the clinical publications examined in this chapter suggest that surgical intervention to produce positive body image or body image satisfaction is an acceptable treatment for problems of body image because the overwhelmingly positive results demonstrated in particular by outcomes studies establish a published record of success that testifies to the usefulness of elective breast surgery. The high rate of “successful” transition is measured and affirmed by the numerous outcomes studies and surveys cited here that reveal, over long- and short-term post-operative periods, the high degree of patient satisfaction in terms of the improvement or reduction of “symptoms” like poor self-esteem, lack of self-confidence, shyness and withdrawal. In leveraging medical expertise so as to legitimize the extension of its power to a breach of aesthetic and attitudinal “norms,” health care professionals justify the regulation of women with body image dissatisfaction and surgical intervention comes to represent that which carries the possibility for transition from problematic to healthy body image.

The Role of “Expert” Discourse in Processes of Normalization

It is also important to consider who is expected to read these publications as well as the significance and implications of the authorship and intended audience of this research. Because these studies and articles are primarily published in journals that focus on aesthetic surgery, nursing care, or general medical practice, it is evident that health care practitioners are addressing other clinicians and surgeons. In turn, these articles and studies are not intended to be read by the public or, more specifically, by women thinking about having elective breast reduction or augmentation. Thus, the conversation about female body image and elective breast surgery that takes place in these articles is one that is intended to take place between peers.

What surgeons and others health care practitioners communicate to each other about female body image and elective breast surgery is a significant mechanism in the normalization of female bodies and body image. As has been established elsewhere surgeons and health care practitioners serve as “experts” who, through their knowledge and training, have accrued the power not only to posit and establish norms but also to support people in their compliance with these norms (Morgan 1991). Practitioners are thus an important part of normalization because their articulations of what is normal—informed, in this context, by a combination of anatomical, social, and aesthetic standards—signify the expression of a particular preference, generate the techniques that can identify derivations from that preference (e.g., observation of the body; questionnaires about body image), and also implement regularizing mechanisms (e.g., surgery). In the context of body image and elective breast surgery, practitioner discourse establishes healthy or positive body image as the norm and from there justifies the execution of decades of studies to determine the extent to which individuals (primarily women) conform or fail to conform to this norm. Women who, following observation by the practitioner’s touch or

standardized questionnaire, cannot conform to the norm because they express the characteristics and symptoms of negative body image in combination with the physical presence of “abnormal” breasts are invited to participated in homogenizing measures, first at the level of the body by producing acceptable breasts (in terms of appearance and size) and second at the level of behaviour in terms of conformity to a positive/healthy attitude toward the body.

Conclusion

This chapter has explored how body image functions as a concept that is deployed in relation to the disciplinary regulation of women’s bodies and subjectivities. I established that peer-reviewed, clinical publications about elective breast augmentation and reduction engage an uncritical acceptance and reinforcement of the popularized understanding of “body image.” Discourse analysis revealed a dominant narrative of body image present in this literature. This narrative states that breasts are significant in the development of female body image, perhaps uniquely so, and that dissatisfaction with the breasts will generate a range of problems with body image. In turn, women who have body image problems will be motivated to undertake breast augmentation or reduction, two procedures that are, according to the literature, proven to ameliorate or eliminate body image problems.

Focusing on what practitioners who are involved in carrying out elective breast surgery communicate about the purported effects of such procedures, this chapter proposed that the concept of body image functions in this literature to produce a normalizing effect. In the clinical literature on the practice and outcomes of breast augmentation and breast reduction surgery, “body image” and “body image dissatisfaction” (or “body image distortion”) are mobilized as objects of knowledge. My analysis suggests that the mobilization of body image in this context opens up the possibility for elective surgery to function as a mechanism that regulates women’s

bodies at the level of conduct as well as morphology, changing bodily orientation so as to generate subjects who are more productive socially. The mobilization of body image language by practitioners generates modes of communication (e.g., studies, surveys) that, insofar as practitioners espouse the positive outcomes produced by surgery, come to function as the evidence that establishes elective breast augmentation and reduction as effective means by which to regulate subjects. In this way, it is not only surgical practice but also surgical discourse that becomes a technique through which individuals can be shaped through medical intervention.

This analysis has also revealed that elective breast surgery is promoted as an acceptable solution to “problems” of body image and that the female breast is positioned and promoted as an object first for scrutiny based on surgical aesthetics and second for surgical intervention to ensure conformity with normative standards. I have suggested that clinically oriented publications on breast augmentation and breast reduction surgeries engage the popularized notion of body image, connecting body image to self-esteem, self-confidence, body anxiety, quality of life and general well-being. In relying on this popularized notion, clinical publications on body image and breast augmentation and reduction surgery become characterized by a particular account of women’s motivations for and experiences of these two surgical procedures. This literature propagates a narrative of breast surgery and body image that works to justify and promote surgical intervention as an effective and appealing solution to “problems” related to body image. In turn, elective breast augmentation and reduction surgery become appropriate forms of self-care.

Practitioners’ continued subscription to the popularized notion of body image compels women to participate in—and thus enables surgeons to defend—interventions that produce a normalizing effect. The normalizing effects of surgery are, I suggest, supported by the impetus to

regulate and diminish the prevalence of negative or distorted body image. The opposition between positive and negative body image colludes with elective breast surgery wherein both become forms of social power that actively produce subjects who comply with established modes of communication and conduct that first rationalize surgical intervention and then affirm its effectiveness. Body image, I suggest, is a concept that is mobilized as a regulatory mechanism and an organized set of constraints in ways that have significant implications for women and female body experience in Western societies and cultures, in that this conceptualization of “body image” is leveraged to justify surgical intervention and normalizing modifications to body *and* self. Ultimately, surgical intervention through elective breast augmentation and reduction is established as the means by which to transform and reinvent at the level of the self/individual. When body image can be transformed from positive to negative through the use of elective surgery, the concept functions as a locus at which to surgically regulate and regularize individual attitude and conduct. In this case, the clinical literature on the relationship between breast augmentation, breast reduction, and body image reinforces the idea that body image (dis)satisfaction emerges first and foremost within the individual. The transformative potential of breast augmentation and reduction surgeries operate in a context that responsabilizes the individual as the cause and relief of their own suffering. Under these circumstances, pathological behaviours become pathological identities and individuals interpret themselves as subjects and submit themselves for care; the discourse of body image validates women’s concerns as legitimate and grants them subject-status.

As an individual and personalizable pathology, body image dissatisfaction or distortion becomes a technique of normalization that then shapes how individual women accept and participate in the perpetuation of extant developmental, appearance and surgical norms, which

exist here in a relationship of equivalence. As a result, surgical intervention for the sake of positive body image produces corporeal homogenization but it also produces homogenization at the level of subjective relationship and attitude towards the body, specifically because elective surgery, in this case, endeavours to produce a coherence between internal perception and material reality. The degree of change in internal perception, an aspect of “subjective” lived experience, is measured through the “objective” measures of pre-fabricated, closed-ended questionnaires. In other words, the articles and studies that comprise this set of studies and articles on body image and elective breast surgery do not engage in a full or sustained way with the subjective experience(s) of their patients. The survey instruments and questionnaires are not conducted with patient input nor do they unequivocally represent patients’ voices. Although the studies and articles are focused almost exclusively on motivations and outcomes, they report these findings without supporting them with narrative accounts from their patients. In the next chapter, I turn to my own study of women’s experience(s) with elective breast augmentation and reduction and consider what happens to the narrative of body image when we centralize the words of recipients of surgery rather than write over them and when we ask questions that turn in a direction different from a relentless focus on the intrinsic motivations for and transformative outcomes of these surgeries. The next chapter considers whether we can come to a different understanding of the relationship between elective breast surgery and body image when women narrate their own experiences of surgical intervention.

CHAPTER 4: OPEN EMBODIMENT: A PHENOMENOLOGICAL INQUIRY INTO BODY IMAGE AND ELECTIVE BREAST SURGERY

Introduction

In 2014, I had a conversation with Leanne about her experience with breast reduction surgery. Leanne is now 50, and she lives in a city in Northern Ontario with her husband and two daughters. She had breast reduction surgery in that same city in 2003, after many years of chronic back and shoulder pain alongside an unwelcomed change in the size and shape of her breasts following her two pregnancies. While Leanne is happy that she had breast reduction surgery, she experienced a significant amount of pain in the weeks immediately following her procedure. When I asked her if her sense of her body changed after she had breast reduction surgery, Leanne focused her response on her immediate, post-operative experience and told me the following:

There was a lot of pain after the surgery, while I was healing. I was off work for about four weeks. The first week was unbearable. [...] Because I had experienced so much pain, there was this feeling of a barricade around—an invisible barricade I had made around myself, where I walked around with a pillow for the first week or so because I was so afraid of the pain, or of banging or someone coming near me. I had small children at the time so I was very [cognizant] of *Don't touch me! Don't come near me!* (laughing) That dissipated probably after a month when the healing actually started taking place [...] But again there was always that mental barrier I had around the front of me because I was so afraid of getting banged into.

Here, Leanne explains that because she was in a lot of pain, she became protective of her body in order to avoid exacerbating her pain. To be clear, her motivation to protect her body and her self

comes from both an experience of pain and a fear of pain. Leanne emphasizes not so much the severity of the pain that she experienced, but the way that post-surgery body pain impacted how she moved around the world, and what it was like to engage the world. She refers to her experience of post-surgery pain as “the pain,” as something external to or outside of both her self and her body, and as an experience that could have been returned upon her and her body had she not been precise about how she moved about the world. Here, she identifies having been afraid of both “the pain” itself and of activating an encounter with “the pain.” At the time of her recovery, Leanne associated different kinds of closeness—to objects, to her children—with the possibility of pain. Leanne, understandably, wanted to avoid aggravating the pain. Her experience of being in pain and fear of additional or future pain experience animated the creation of a “barrier” between her self and the world. This barrier allowed Leanne to avoid experiencing the pain that contact with the world threatened to bring upon her.

Leanne’s comments reveal that, in the first few weeks after her surgery, her perception of the world changed. She arranged her movement in and interaction with the world in accordance with this different perception. Things that were once innocuous—namely, her children—became newly threatening to her, for interaction with them carried the possibility of pain. The fear that Leanne had of triggering an experience of further pain took the form of feeling and having a “barrier” around her, an obstacle or a blockage that prevents contact and communication. Interestingly, Leanne speaks of both an “invisible” and “mental” barricade that she created around herself, but she also talks about carrying a tangible barricade—a pillow—which she used to “shield” herself from the pain-inducing outside world. Eventually, as she healed, Leanne came to be more at ease in the world, but for the first few weeks, she placed limitations on her

engagement in the world and adversely reacted to potential interaction with the others and objects in the world.

Leanne's story provokes some interesting questions about the ways in which surgical intervention alters how we engage with the world from within and outside our bodies. How does surgical intervention change our relationship to and with our bodies? In what ways does surgical change to the body subsequently change what our bodies can do? What does surgery mean for the ways that our bodies interact in and with the world? How do people who experience surgery "incorporate" the resulting physical change? The previous chapter demonstrated that clinical discourse on elective breast augmentation and reduction understands and represents such interventions as ones that can positively transform women's lives at the level of body confidence, self-esteem, well-being, and quality of life. This chapter focuses on women's first-hand accounts of breast augmentation and breast reduction to explore how surgery changes women's lived experience of the body in its material and felt sense.

Chapter Objectives

In this chapter, I think through what surgery means for how our bodies move about the world, and how the relationship of the self to the post-surgical body shapes the way that we understand the possibilities that that body can enact. Working with the results of semi-structured interviews that I conducted, this chapter focuses on women's lived experiences of surgery. This chapter situates interview texts in the context of phenomenological inquiry to consider how bodily change created by elective breast augmentation and reduction is perceived, thought, felt, and responded to by women who have had these procedures. This chapter offers a phenomenologically motivated exploration of adult women's lived experiences with breast augmentation and breast reduction surgery. In contrast to the previous chapters, which

considered first theoretical and then clinical-discursive articulations of body image/schema, this chapter draws on women's lived experiences to consider how the body image/schema is lived in the everyday.

Following Toril Moi (1999), I understand "lived experience" to be that which "designates the whole of a person's subjectivity [and] describes the way an individual makes sense of her situation and actions" (63). Moi suggests, following de Beauvoir, that woman's "situation" is wide-ranging and inclusive of other markers of identity such as age, race, class, and nationality. She goes on to say that "because the concept also comprises my freedom, my lived experience is not wholly determined by the various situations I may be a part of. Rather, lived experience is, as it were, sedimented over time through my interactions with the world, and thus itself becomes part of my situatedness" (Moi 1999, 63). Lived experience is thus at one and the same time personal, social, cultural, and comprised through our bodily histories. Feminist theory and politics has had a sustained interest not only in accounting for women's lived experience(s) but also in attending to how lived experience is shaped by and at the intersections of race, gender, class, biology, gender identity, ability, religion and size (e.g., Ahmed 2006; Alcoff 2006; Mairs 1996; Salamon 2010; Slatman 2012; Young 2005). As Sonia Kruks (2014) writes, "phenomenology offers us access to significant registers of women's lives, to embodied and affected ways of knowing, judging and acting that cannot be grasped by discourse analysis or by other objectivizing approaches to 'experience'" (90).

This chapter, like the previous chapter, examines the effects of elective breast surgery through the concept of body image(s)/schema. I take up the phenomenological conceptualization of body schema in this chapter in order to both think with and against the normative and normalizing function of body image that was examined in the previous chapter (e.g., Gallagher

2005; Merleau-Ponty 2013; Schilder 1950; Weiss 1999; Young 2005). Body image, as I explored, surfaces as a concept that produces normalizing effects at the level of the body and the body image in the way that it is leveraged to promote elective breast surgery as a plausible and effective solution to the discursively produced and clinically legitimized problem of body image dissatisfaction. Yet the way that body image functions is leveraged in the prescription and justification of surgery does not account for the complexity and idiosyncrasy of women's lived experience vis-à-vis the felt sense of the body (Barina 2015). Importantly, then, this chapter is also informed by the insights of phenomenological inquiries into health and illness and thus intends to, against the clinical orientation considered in the previous chapter, recover and articulate actual lived experience in the face of medicalized objectification and quantification of the body. As was articulated earlier, phenomenological inquiries into health and illness critique the way that biomedical approaches dehumanize patients by focusing on the body's malleability; in turn, phenomenologists work toward generating theories of and approaches to care that attend to people (de Boer, van der Hulst and Slatman 2015; Leder 1990; Shildrick 2008; Slatman 2016; Slatman et al. 2016; Toombs 1992; 2001; Weiss 2014). In drawing on interviews with recipients of surgery, this analysis centres concrete, lived experiences provided by adult women so as to focus on bodies as they are intertwined with individuals and the world and not solely in their function as material or objective entities.

The chapter takes as its focal point the unique trajectory of embodied possibilities vis-à-vis the body schema. In other words, it emphasizes the manner and means by which surgery calls for and instantiates a reorientation of the body and its habits and reveals the body schema as the body's openness to the world. An exploration of these conversations attuned to the interests and insights of phenomenology allows for the consideration of how bodily change created by

surgical intervention on the breast is perceived, thought, felt and responded to by women who have encountered it, in terms that are distinct from the over-emphasized problems of self-esteem and body confidence. Informed by the concept of the body schema in phenomenology, this chapter works through if, how, and in what ways breast augmentation and breast reduction surgeries provoke a shift in the individual's conception of the lived body and its possibilities by exploring similarities and differences in women's experiences of these surgeries. A central objective of this chapter is to draw on the sustained phenomenological attention to lived bodies so as to explicate, to the extent that interviewee testimony disrupts notions of "body image," that the biomedical engagement with the body is always already incomplete. My hope is that such an exploration and application will create the possibility to think differently and more openly about the effects of elective surgery. This chapter proceeds as follows. First, I describe the process of recruiting and interviewing the participants, the method for preparing and analyzing the interview transcripts and the method for generating themes. Here, I also present and briefly describe the five themes that emerged in the process of reviewing and analyzing the transcripts. From there, I offer an account of how each theme is borne out in women's stories of breast augmentation or breast reduction surgery. To conclude, I synthesize the findings of women's lived experiences of breast augmentation or reduction by thinking across the themes, and then situate these conclusions in relation to the phenomenological concept of body schema.

Elective Breast Surgery and the "Opening" of Embodiment

Methodology

From May to November of 2014, I conducted 11 semi-structured interviews with participants living in urban centres across Canada. All of the people that I spoke with identify as women, while one participant identifies as both a woman and "loosely" as trans. Seven of the

participants underwent breast reduction while the remaining four underwent breast augmentation. At the time of this writing (January 2015), the participants range in age from 27 to 53. The average age of the participants, again at the time of this writing, is 34.9 years of age; the average age at the time of surgery was 28.8 years of age. Four of the participants underwent surgery as many as 10 years before our conversation, while three had their operations only a few weeks prior to our conversation. With regard to racial identification, 7 of the participants identify as white; 1 participant identifies as a person of colour; the remaining interviews were conducted over the phone where the question of racial or ethnic identity did not become part of the conversation. In terms of sexual orientation, 4 participants identify as lesbians, 1 places herself “pretty close to” the asexual spectrum, and the remaining 6 participants identify as heterosexual. All participants are referred to by the name and gender pronoun they told me they prefer.

I talked with each participant for about an hour about the full range of their surgical experiences. We discussed their respective motivations for seeking elective surgery; their feelings about the results of their surgery; their experiences with medical personnel; their preparation and recovery process including any complications; and the effects that breast surgery has had on their bodies, their relations to others, and their understandings of themselves in relation to gender and sexuality. (The complete list of interview questions is contained in Appendix 1; the informed consent protocol is contained in Appendix 2; the ethics approval for this study is contained in Appendix 3.) I keep regular contact with two of the three friends who participated, though their having had surgery is rarely part of our conversations. Beyond sending thank-you notes, I do not keep in touch with the remaining participants, who I did not know prior to our conversation. The participants come from a wide range of backgrounds in terms of class, race, size, ability, education, and geographical location. Their experiences were both sufficiently

varied and had much in common in terms of the effects and affects that emerged in these conversations of their pre- and post-surgical experiences.

The interviews used snowball sampling and began with three friends who offered themselves as interviewees; the remaining eight participants were friends or relatives of my friends and relatives. The interviews were conducted online via Skype, in cafes, in participants' apartments, at my apartment, or over the telephone. All interviews were recorded using a voice memo app and transcribed verbatim using F5 transcription software. Each participant was given the opportunity to review and amend the transcript; four participants took this opportunity but did not request any substantive changes. In analyzing the interviews, I conducted a thematic analysis (Braun and Clarke 2006; see Chapter 1 for a detailed description of this method and its usefulness). As noted in Chapter 1, each interview transcript was read with notes taken along the way to mark initial observations and generate open codes; the codes were generated inductively from the texts. Examples of initial open codes include: "pain," "scarring," "comfortable," "uncomfortable," "change in habit," "sense of femininity," "relationships," "sexuality," "lack of fit," "greater proportion," "bodily adjustment," "different/new experience," and "negative feeling/outcome." At this point, codes were either refined, condensed, or discarded which produced a set of themes. The interview transcripts were reviewed until no new themes could be identified and master themes could be generated. Following this process, five themes emerged: 1) "pre-operative bodily incongruence," in which women discussed a lack of coherence between their internal perception of their bodies and the material reality of their bodies; 2) "post-surgical proportion," in which women discussed a stronger sense of unity between mind and body after surgery; 3) "post-operative spatial reorientation and bodily rehabitualization," wherein women discuss their experiences of having to adjust the "doing" and "living" of their bodies; 4)

“experiential expansiveness,” wherein women explore the ways in which their sense of what was possible for them and their bodies changed; and 5) “shifting sensation,” in which women describe the changes in sensation that they experienced after surgery. Taken together, these themes appeal to a narrative about the body and an experience of being in a body in ways that intersect with the phenomenological conceptualization of body schema. More specifically, these themes intersect with our sense of where our bodies are situated in the world, what can happen with our bodies, what our bodies can do, and how we express and experience ourselves in the world through our bodies.

Pre-Operative Bodily Incongruence

The majority of women I spoke with were motivated to pursue breast surgery due to a felt incongruence or lack of “fit” between their ideas of how their bodies should be manifested and the material reality of their bodies. Many of the participants experienced and expressed this lack of fit in terms of the relationship between breast size and self-perception of the body. Megan, who had a breast reduction, told me that her breasts developed very quickly and that, by the time she started high school, she was wearing a “DD or G” size bra. She said that, because she is a short person, this was “bigger than what [she] was comfortable with personally but also with what [her] body liked.” When I asked her to elaborate on what that meant, she said: “I guess we all kind of have internal images of what we are supposed to look like or how we envision ourselves when we see ourselves, and I never felt that [...] carrying all the weight in my chest fit how I wanted.” Megan did not feel that the size of her breasts aligned or made sense with how she understood or envisioned the proper expression of her body.

This notion of fit emerged in discussions of gender identity as well as body size. Sahar, who identifies “loosely” (their term) as trans, had breast reduction to reduce chronic back pain,

but also to create a stronger sense of alignment between their gender expression and their corporeal expression. Sahar also talked about “fit” in terms of a mental picture or image. They said that, before surgery, they felt like the “surprise of seeing myself in the mirror didn’t necessarily coordinate with the image I had of myself.” Sahar said they engaged in a “conscious cutting off from” their breasts and “skipped that part of my body in order to make myself fit whatever image I had of myself.” Because they did not incorporate the having of breasts into their understanding of their self or their body, Sahar reconstructed the image of their body in order to accompany and affirm their refusal of the breasts as a part of who they are in terms of gender identity.

Struggles over fit were also expressed in terms of feeling “uncomfortable” with the size of one’s breasts and, as a result, with one’s body. Romanda, who had a breast reduction, said that, when one has large breasts, “you’re aware that they’re everywhere.” She described the lack of “fit” in terms of not feeling “at home” in her body. “It’s more like a constant, *I’m uncomfortable, and I can’t find a place that I’m comfortable,*” she said. “You’re constantly moving around.” Danielle was motivated to have breast reduction because it was “incredibly annoying” and “inconvenient” that her breasts “didn’t fit into anything” in terms of clothing. This annoyance motivated Danielle as well as Lindsay to “hide” their breasts under loose-fitting clothing. Carly, Allison, and Kylie, three women who underwent breast augmentation surgery, also talked about fit, but they explicitly linked “fit” to their respective senses of femininity. Each of these women had different ideas about what constituted femininity both personally and in the broader social context, yet all felt strongly that their bodies did not fit their ideas about what it meant to be feminine. Carly, Allison, and Kylie all said that they underwent breast augmentation “to feel more feminine” and, for Carly and Allison, to achieve “a fuller figure or more curvy

figure.” These three women, who wore padded bras for years, all sought to have breasts that were “permanent.” When uncomfortable with the size of their breasts—whether too small, too large, not feminine enough, or too feminine—women felt uncomfortable with their bodies overall, and made modifications in order to produce an increased sense of embodied comfort.

Other participants described their struggle with fit in terms of breast shape. SJ and Leanne told me that the shape (and size) of their breasts changed dramatically after their respective experiences with pregnancy and breastfeeding. SJ, who had a breast augmentation, expressed a newfound discomfort with her breasts as a result of the “complete transformation” of her body following childbirth and breastfeeding. Once very happy with her breasts, SJ found herself having a “hard time” accepting the post-partum change to her breasts. Even though SJ was “doing everything on the outside,” such as following a healthy diet and exercising, she knew that only breast augmentation surgery would restore for her an internal comfort with her breasts. In contrast, Carly, who also had a breast augmentation, was dismayed by a loss of “fullness” in her breasts—attributed to “aging and switching birth controls”—and was motivated to have surgery due to disappointment with and exasperation over her inability to fit into clothing. “Not being able to fill [clothes] out” really “wears on you” and “messes with your head,” she told me. Unlike other women, like Megan for example, who experienced a disconnect between the perceived and material realities of their bodies, Leanne, SJ, and Carly expressed a lack of fit because of a tangible or material change in their breast shape that was misaligned with what they knew of their bodies and how they felt comfortable. In terms of breast shape and size, all of these women felt that they experienced a disconcerting lack of “fit” between what they imagined or thought to be the proper expression of their bodies and the physical realities of their bodies.

The interview commentaries cited above demonstrate a range of knowledges of the body and, with them, a variety of sources of knowledge of the body that reflect Schilder's (1950) articulation of the body schema. The women I interviewed described a variety of experiences of disrupted body schema. Danielle and Carly, for example, felt this disruption because of a lack of "fit" but this knowledge came in part from negatives experiences they had buying clothing for themselves. Megan and Sahar both described that their felt sense of their bodies was not aligned with the actual material expression of their bodies, leading them to feel out of place in or alienated from their own bodies. Romanda described a similar experience, discussing how physical discomfort made it difficult for her to fit into her body in both motor and sensory terms. The sense that Carly, Allison, and Kylie had about the manifestation of their bodies was aligned with their respective experiences and understandings of femininity. Each of these women had a different conceptualization of femininity. Carly associated femininity with a "fuller" or "curvier" figure defined by "full breasts and hips," while Allison defined femininity in terms of her childhood memory of her mother's body. In these cases, the understanding of femininity and, in turn, the sense of how their own bodies came from these women's relationships and interactions with the bodies of others.

The experiences of Leanne and SJ are particularly revealing in terms of knowledge of the body. These two women carried an understanding of their bodies that was based on a particular morphological expression. When that morphology changed after pregnancy and breastfeeding, Leanne and SJ both experienced a disruption in their knowledge of their bodies and, as a result of this newfound unfamiliarity, great distress. They once had a knowledge of the body that aligned with the body's manifestation, but then, after the body change that came with pregnancy and breastfeeding, felt they did not know their bodies anymore. In all of these examples, the

experience of the body is wrapped up with desire, gender, personality, sociality, and intersubjectivity. Through these and other sources of knowledge, one comes to make sense of and understand themselves as a corporeal and embodied being. Importantly, none of the women that I interviewed were, prior to surgery, in positions where they were devoid of knowledge of their bodies; instead, the point is that how they knew their bodies was not consistent with how their bodies were physically manifested in the years or months preceding surgery. When one's knowledge of the body does not align with the material body this leads to a disruption of the body schema; in turn, one can no longer make meaningful sense of their status as embodied.

In many cases, participants attempted to reconfigure the body schema to be in alignment with their knowledge of their body. Many participants detailed for me the manner in which, prior to surgery, they adjusted their bodily orientation and expression in order to alter the presence of their breasts in order to establish a sense of "fit." For some of the women who had breast reduction, this adjustment usually involved reorienting the body so the breasts were less visible or present. Sahar, who had breast reduction described pre-operatively "trying to mask mentally or physically the size" of the body by "rounding" their back. Megan talked about experiencing years of "bad posture" as a result of the attempt to minimize breast size; her poor posture could only be remedied, she said, by the removal of breast weight. She also said that she "tried to disguise it [her breast size] by having a larger weight [but] never felt like it was how I was supposed to be." Because Megan sensed that her breasts were too large relative to the size of her body, she tried to create a sense of balance or proportion by increasing her body weight to "match" her breast size. However, Megan did not feel that she was "supposed" to be in a heavy or fat body. Romanda said she "started to walk with my shoulders hunched forward and to my sides; my arms were forward so they would block part of my breasts" as a direct result of being

teased during her early adolescence by female classmates. Romanda was quick to emphasize that, at this time, she did not carry herself in a manner that “flaunted” her breasts but that having “good posture” made her breasts more noticeable and in turn made her subject to ridicule. In contrast, for some of the women who experienced breast augmentation, this alteration involved increasing the size of their breasts via their clothing. Carly, who had a breast augmentation procedure, indicated that pre-operatively, she was an “empty shell.” She talked about “being curved in towards” herself prior to her procedure. Allison, who also had breast augmentation, also talked about being “curled” inward. Both of these women wore padded bras to generate a sense of full-breastedness and to eliminate the tendency towards “curling.” All of these women adopted one or more behaviours that allowed them to either disguise or be more comfortable doing their bodies in relation to their breasts.

The interview examples cited thus far, which are taken from women’s pre-surgical experiences, indicate that the women cited had a knowledge or awareness of the body that was incongruous with the reality of the body’s material expression. The women I interviewed discussed a lack of “comfort” while in their bodies, which affected the manner in which they engaged in the world. Each engaged in strategies to reduce or eliminate this sense of incongruity. Being “curved in towards” oneself was one way of restoring the disrupted body schema and of consequently “doing” the world with slightly more ease and contentment. Also, many of the women cited had a knowledge or understanding of their breasts in terms of the “proper” expression of their body, in relation to their psychic and personal experience, but this understanding did not connect with the actual size and/or shape of the breasts. To create a stronger sense of alignment, several women engaged in psychic and/or physical behaviours that allowed them to align the physical body with the body schema. These include “skipping” the

breasts when looking at themselves, like Sahar did, expressing their posture differently so that their body was more aligned with their body schema, like Romanda did, or gaining weight to disguise the breasts through the creation of a more “proportioned” body, like Megan did. The action of “skipping” allowed Sahar to complete their knowledge of their body and engage in the world with a more complete body schema, or a body schema that was more representative of their felt knowledge of their body’s right expression, particularly in relation to gender identity. The action of re-creating one’s posture in response to hurtful negative commentary from peers, like Romanda describes, indicates a semi-conscious physical response to psychological distress. This action evidences how the three dimensions of body schema—psychological, physical, and sociological—interact in its formulation and re-formulation. In the commentaries above, it is evident that women engaged in a range of conscious and semi-conscious efforts and behaviours that allowed them to revise the body schema in accordance with their felt knowledge of the body. In this way, we see that the body schema is a knowledge and experience of the body that is dynamic, and that is in perpetual self-construction, revision, expansion, reduction, and self-destruction (Schilder 1950, 16, 204). Because of this status of the body schema as “living,” the building-up or construction of the body schema requires our ongoing effort or a continuous exercise of “body work.” Women who are uncomfortable in their bodies because of their breast size and/or shape engage in an ongoing reconstruction of the body schema that allows for a more complete and unified embodied expression of the body. Importantly, though, this reorientation of the body schema should be understood as a means by which mental representation and physical morphology are made to more closely align prior to surgical bodily change. Many of the women interviewed here experienced distress (physical or psychological) and/or musculoskeletal problems as a result of these reorientations, and this was a determining factor in their decision to

have surgery.³⁴ The descriptions above demonstrate how women who are uncomfortable with the size of their breasts will literally and figuratively shrink or expand in the body in an attempt to shift the amount of space it takes up and the extent to which they are “projecting” their breasts. Through this practice of “expanding” or “shrinking,” they engage in the maintenance and recreation of the body schema. By working to make themselves more “at home” in their own bodies, they demonstrate the flexibility of the body schema and show how these modifications of embodied expression are a way to avoid disruption to the body schema.

Post-Operative Proportion

The theme of “fit” continued to be present in women’s discussions of their experiences of and feelings towards the body after surgery. While, as discussed earlier, several women expressed a lack of fit, both in terms of the respective parts of the body and in terms of their own idea of the body in relation to the body’s physical reality, others experienced a stronger sense of “fit” after their surgery. Many of the respondents talked with me about how they felt that the respective parts of their bodies “fit” together better after surgery, or that their bodies were now in better “proportion.” Kylie, who had a breast augmentation, said, “I’ve gained about 15 pounds [in the three years since the surgery] but I feel a lot more comfortable having some more curves to my body and it’s not an issue for me. I just feel more balanced.” Others talked about experiencing a feeling of proportion and good fit, which, for them, connected with a newfound confidence in and happiness with their bodies and comfort in their embodied experience. Lindsay, who had breast reduction surgery, said “I feel like [surgery] put my body back into

³⁴ All of the recipients of breast reduction surgery had the procedure covered by their provincial health care system. Many of these women experienced chronic back pain as a result of the weight of their breasts. Some did not have pain, or did not consider their pain to be severe; instead, they were motivated by problems with clothing, restricted physical movement, or inconsistency between their gender identity and bodily expression. But, they knew that a claim of chronic and severe pain was necessary to have the cost of the procedure covered, and so they offered chronic pain to the referring physician as the “official” reason for surgery.

proper proportion. I definitely feel that, post-surgery, I had a more positive relationship or outlook on my body. For the first time in a very long time I felt comfortable in my own skin and completely confident.” Carly said: “I feel proportionate in every way. Before, I felt like I just had a hollow, empty chest, even though I had [breasts] there, but now I just feel like my chest matches my behind, which also matches everything else. And I carry myself a lot better and I’m just happier, like, my mood is happier.” Several of the women I interviewed expressed that they now experience a sense of coherence between their felt sense of their bodies and the physical manifestation of the body, which they did not experience before. The pre-surgical disruption of the body schema, expressed in terms of lack of fit, created the possibility for renewal of the body schema, and, in these cases, it was surgical change that allowed women to experience proportion or coherence between the felt sense of the body and the actual manifestation of the body.

It is crucial to emphasize that the women who talk about greater proportion, balance, and fit after having had surgery indicate not just that their bodies are now in proportion. Instead, they connect proportion and balance with themselves as individuals: “*I feel proportionate*,” or “*I just feel balanced*.” The commentaries cited here indicate that these women do not hold a separation between the body and the self/mind. It is not that the body is proportionate, or that the body is more balanced, but that the self, too, is balanced and/or proportionate. The women I interviewed talked not about how their bodies felt pain or generated annoyance or discomfort; rather, they shared that “I” do not fit into clothes (Carly), or “I” felt uncomfortable (Romanda). They recognize that they are their bodies and that, for them, a balanced body is a balanced self. The interaction between the visual and the tangible was crucial to all of the interviewees’ formulations of their body schemas, insofar as there was a disconnect between the felt sense of the body and its appearance and tangible manifestation.

Post-Operative Spatial Reorientation and Bodily Rehabitualization

Several women described to me that, immediately following surgery, they were afraid of experiencing pain in their breasts, so they generated imagined—and, in some cases, actual—barriers in order to mitigate injury or further pain. This experience, which was common whether the women experienced breast reduction or augmentation, took two forms: spatial reorientation and bodily rehabitualization. As described at the outset of this chapter, Leanne had a significant degree of pain following surgery, which provoked the creation of both an imagined barrier and an actual “barrier” (a pillow) to protect herself from experiencing pain. Other respondents had similar experiences where, in order to protect themselves from pain, they imagined that the body as a whole had expanded. Allison, who experienced breast augmentation, said, that “I had to be very careful because I was very sensitive. I had to wear this [...] giant granny bra, with all these hooks up the front so it was super, super supportive [...]. I kept a little border around me. People couldn’t come close. I was nervous.” Despite having the support and enclosure of the “giant granny bra,” Allison still felt that it was necessary to create a “border” between herself and the world. Megan described this as well, saying that “Certainly, after the first few times I would go out, when I was feeling well enough, there was a conscious decision of, *Don’t let anyone brush up against me because it’s going to be painful.*” In opposition to the attempted “shrinking” of the body and self in which many of these women engaged prior to surgery, there was a clear experience of a felt or created “expansion” of bodily space after surgery in order to protect the self from harm or pain.

Spatial reorientation was also expressed as distinct from pain. There was a general need to reconstruct the body schema to internalize or account for the new spatial orientation of the

body. Megan, who had had breast reduction surgery just one month before we met, described the following:

It's a substantial amount that I have to kind of re-evaluate where I fit into passing people or walking by or something like that, there is less of me out there but I still expect to brush up against people. [...] Only a month ago or you know, I was further out. So there was this constant sort of reminding myself that, *No, this person can get through*, or *You can fit through this space, because it's* [her breasts] *not there anymore*. I'm conscious of it but subconsciously it hasn't adjusted yet. It's getting better. I'm finding myself catching myself less and less.

Similar to Megan's experience, Allison also talked about a time of spatial reorientation. She said, "I would bump into things a little or my friends would be talking and they'd hit me with their elbow and I'd really notice it. [...] Sometimes they [still] get in the way. If I'm reaching for something, and I feel them in the way—but I'm used to that [now], too. Sometimes I laugh about it and I think, *Oh yeah, you had to get them big*." Carly had a similar experience. She had a breast augmentation procedure just two weeks before we spoke. She said:

I was sneaking through my patio doors last night and I just realized that usually [...] I could slip through and not have a problem but I went to slip through like I usually do and my boobs got in the way (laughing). And I was like, *Oh, right*. [...] Or you go to grab something and your arm hits your boob and gets in your way.

In the examples cited above, women described for me how their post-surgical experiences of their bodies were accompanied by pain and sensitivity that, understandably, they wished to avoid worsening. In order to avoid pain, Leanne, Megan, and Allison made the body larger than it actually was—they generated an expanded body schema that incorporated an

imagined or literal “border.” They imagined this border around the self (“me”) rather than around the affected body part (“my breasts”). This is crucial, for it affirms the manner in which the body’s parts envelop each other, and are often, but not always, indistinguishable. While both Megan and Allison generated imagined borders, they recognized the border as a creation that was reflected in their resulting motor activity. The reconstruction of the body schema in this manner protected these women from the experience of pain in the weeks immediately following their surgeries. Through an expanded body schema, Leanne, Megan, and Allison each uniquely determined how to express their recovering bodies in space in terms of making contact with the world through a consciously imposed distance.

In these experiences of spatial reorientation, Megan, Carly and Allison describe the ways in which they adjusted the body schema in the direction of the newness of the body’s situatedness in space. The descriptions from Megan and Carly are interesting when read alongside one another. Megan’s description shows how her consciousness is aware of the change in the situatedness of her body, but that her “subconscious” has not yet incorporated this to the point of habitualization. Carly’s description, in contrast, shows how there is neither cognitive nor motor awareness of the change in the body’s situatedness. Allison’s experience shows that there has not been a full reconstruction of the body schema, for even though she told me that the implants are now part of her, there are still incidents that reveal a less-than-full incorporation of the breasts into the body schema. These examples are revealing in light of the manner in which Schilder (1950) describes our knowledge of the body and our enactment of the body schema, as a dynamic cycle between vague and clear on the one hand, and partial and complete on the other hand.

Each of these women described to me one or more bodily adjustments that were generated directly by the bodily changes brought on by breast surgery. The experience of surgery came with many adjustments, which are connected more closely to specific bodily adjustments that they adopted rather than to a general spatial reorientation. Several of the women I interviewed described that they were provoked to adjust the body to the world in which they live, which can also be understood in terms of reconstruction of the body schema. The body schema, for Merleau-Ponty (2013), comprises the tacit manner in which we “do” the body in the world without awareness of the body’s movement (172). As I write these paragraphs, I occasionally remove my right hand from the keyboard, take hold of my mouse, highlight and then delete unwanted words or sentences. I know the keyboard shortcuts that allow me to save my work, to move to different locations on the screen, and to delete words or entire lines of type. My accomplishment of this task does not require me to be conscious of or think consciously about how I must move my arm away from the keyboard or that I have to take hold of the mouse. The use of the mouse has, over time, become a habit, or an extension of my body. When we acquire a habit, we are reworking and renewing our body schema (Schilder 1950; Merleau-Ponty 2013): “in the acquisition of habit, it is the body that ‘understands’” (Merleau-Ponty 2013, 145). When learning new movements, such as a new dance, the body “catches” and “understands” new movements; habit generates a synchronization between intention and realization (Merleau-Ponty 2013, 144-146). In the generation of habit, the body schema has to be flexible (Schilder 1950), allowing for continuous synchronizations. In the example of typing, the experience of my body is not a series of distinct motor activities but rather a coordinated realization of an intention, not to use my mouse and keyboard, but to improve the ideas contained in this paragraph. Crucially, then, the body schema is inextricably bound with the acquisition of habit, of which the

aforementioned description (writing on a computer) is an example. Merleau-Ponty (2013) explores the distinctions and intersections between motor habit and what he calls “habit in general,” noting that “every habit is simultaneously motor and perceptual because it resides [...] between explicit perception and actual movement” (153). He writes about how children learn to see and distinguish between the different colours in the world. This learning, he writes, “is the acquisition of a certain style of vision, a new use of one’s own body; it is to enrich and to reorganize the body schema” (Merleau-Ponty 2013, 155). Here, we see that both motor and perceptual activity can become habitual.

For several participants, the experience of surgery called for active engagement in a rehabilitualization of the body. The above descriptions from Megan and Allison indicate as much. Further, even though she was still in recovery and unable to engage in exercise, Carly predicted that the change in her bodily orientation would affect the way she would engage in the activities she enjoyed, such as yoga. She also anticipated that she would have to figure out how to feel comfortable on a massage table or while at the chiropractor. Carly recognized that she would have to actively adjust her body in order to realize her regular participation in certain activities. While she was not yet sure what that might feel or look like, Carly anticipated a rearticulation of her body in order to participate fully and freely in certain activities. Allison experienced changes in her experience of “doing” her body, or of being in her body in the world. For instance, Allison is a teacher, and she developed certain bodily habits in her classroom. For example, she told me that “if I’m in class and I have a top on that’s low cut or showing cleavage, [...] if I bend over to help a student, I’ll hold my shirt to my chest. That’s different. I never used to do that before.” Both Carly and Allison developed new habits or anticipated the rearticulation of habit in order to determine how to reconstruct the body schema and engage in the world anew after bodily change

induced by surgery. Both Carly and Allison discuss the challenges they faced or anticipated facing in making breast implants an extension of their bodies.

Experiential Expansiveness

Several of the women I interviewed detailed how their experiences of surgery, whether breast reduction or augmentation, impacted not only how they relate with their bodies, as was demonstrated above, but also how surgery has affected their sense of embodied experience. Many women had, after surgery, a changed sense and understanding of what their bodies could experience and what their bodies could do. Many women expressed that surgery opened up different embodied possibilities for them: surgery allowed them to do and feel things with and in their bodies that they were not able to do before, or allowed them to do certain things in a fuller sense than they once did. Sahar, for instance, talked at length about how breast reduction has impacted their embodied experience in terms of the connection between their sexuality and their gender identity. Sahar told me about how a reduction in the size of their breasts has allowed them to wear a breast binder. For Sahar, binding has “provided a certain agency—or, like, you could say ‘options’ instead of agency—to be able to enact or perform what I want to be in [intimate] situations [...]. Binding allows me to get somewhere else in my head [...]; there’s a freedom to that.” Although they were disappointed that surgery did not remove as much breast tissue as they would have liked, Sahar was still pleased with the results, because it opened up possibilities within sexual encounters that were not there before. Through binding, Sahar can more easily create a mental space wherein they can imagine themselves “as a man” and, if they want, engage in sexual activity “as a man.” This possibility was indirectly created by breast reduction surgery, for it was opened up by a surgical reduction in the size of Sahar’s breasts.

Other women talked about an expanded range of experience in terms of physical activity and sport. Joan, who had breast reduction, talked about feeling “lighter and freer” after surgery, particularly because she was now carrying “less weight on my shoulder and back.” Joan described herself as a “sporty gay girl” who can now engage in a range of physical activities (triathlon, running, and golf) without “the ‘girls’ getting in the way.” Like Joan, Romanda also had challenges with sport. She said that, before breast reduction surgery, “I never ran. I was never sporty because it [her breasts] just got in the way. I never felt like I could do sport.” She described pain during sport as well as “embarrassing” experiences during running and wrestling activities in high school. She said:

We always had to do a run every week, and I got to do something else [because running was too painful]. [But] there was one that you can’t get out of, it’s called the milkrun, and I had to do it, but I basically held my arms in front of me for a large part of the time. Not all the time, but a large part of it. And it was just because you were—I don’t know if my parents, they never thought of getting me a proper sports bra, but, even if they did, I don’t know if there would be one that would have worked. I did wrestle, and you had to wear a singlet and even during the wrestling match my boobs still got in the way and made things really awkward because she [her opponent] would grab them—because you’re looking for something to grab.

After surgery, Romanda discovered that she can run without pain and discomfort, which she described as a positive effect and a “big health change. I was like, *Oh my god. I can run.* And I got a sports bra, and it worked [supported her breasts], and I ran without uncomfortable pain and feeling like everyone was staring at me. [...] I did a marathon last year, which would have never been in my thought process [before surgery].” Prior to breast reduction surgery, Romanda’s

engagement in sport was limited due to the physical and social discomfort she felt during physical activity; but, following breast reduction, she was able to engage in forms of exercise that were not possible previously. While breast reduction allowed Joan to more “freely” engage in the physical activities in which she was already engaged, it allowed Romanda to newly discover physical activity as a possibility for her and as an enjoyable activity.

Before surgery, both Romanda and Joan were able to direct their bodies towards sport and physical activity, but they experienced a sense of inhibition or an “I cannot” while doing so. Joan’s engagement with golfing was inhibited by the size of her breasts, while Romanda’s engagement with running and wrestling was inhibited by the size of her breasts as well as the pain she felt during the impact of these activities. Romanda in particular felt her body was not one “meant” to do sport. Also, before surgery, Sahar was able to engage their body in sexual activity, but they also felt constrained (in terms of their sexual expression) by their felt incongruence between their body and their gender expression. Certainly, the experiences of inhibited possibility towards sporting activity are bound up with being embodied as female in a society where, for a long time, sport has largely been the domain of men.

The relationship between gendered embodiment and body schema was first discussed by Iris Young in her landmark essay, “Throwing Like a Girl.” Young references Seymour Fischer’s and Erwin Strauss’s research on sex differences and body schema. Young agrees that their respective findings on the increased anxiety that some women have toward certain body parts and the undue attention that women tend to pay to the body do align with her own findings on female motility and feminine bodily comportment, respectively. Young offers three modalities of female bodily comportment, which derive from a woman’s contradictory understanding of her body as an object and as a capacity. These modalities, she stresses, are not biological; rather,

they reflect the situation of women in sexist society where the lived experience of the female body is that of an object, burden, or thing to be carried around and gazed upon. The modalities are: 1) ambiguous transcendence, where only part of the body moves out toward a task while the rest of the body remains in immanence; 2) inhibited intentionality, where the body reaches toward a project but withholds full commitment of the body to a task; and 3) discontinuous unity, where only part of the body moves or transcends when in motion or reaching towards an end. For Young, these modalities imbue women with a sense of “I cannot,” which contrasts with the notion of “I can.”

Romanda’s and Joan’s pre-operative experiences of physical activity resonates most closely with an “inhibited intentionality.” They could aim the body toward the task of running, for example, but withheld full commitment of the body to this task. Girls’ and women’s lack of body confidence and restricted body movement is provoked by a discord in how we experience our bodies and how society views women’s bodies. Fear of physical injury, discouragement from unencumbered participation in physical activity, and the risk of appearing unfeminine all inhibit our “free” engagement with physical activity (Young 2005). Joan, for example, was inhibited from fully “throwing” her body into sport because of the size of her breasts. Romanda could not fully “throw” her body into running or wrestling due to physical discomfort and fear of pain. Romanda was also inhibited by the negative commentaries of her peers who disparaged her at the level of female bodiedness. “When we were out on the baseball field,” they would say “look at those jugs bounce when you’re running’.” This commentary, when combined with the negative commentary she received in the everyday, created an intense feeling of inhibition for Romanda, who, as a result, never “felt” like she could “do sport.” In her essay on Young’s analysis, Beth Preston (1996) objects to Young’s framing of female motility and spatiality,

arguing that Young offers a phenomenology of the experience of *non*-habitual activity whereas Merleau-Ponty's phenomenology is one of habitualization. Preston (1996) argues that the non-habitual nature of Young's examples means that her analysis is based upon a skewed set of examples that place the female body in unfamiliar or unpracticed settings like sport. From this perspective, Preston (1996) argues, Young is bound to find fault with how women perform activities in which their participation is *not* habitualized. Despite this critique, Young's modality of "inhibited intentionality" remains useful to understanding the ways in which female embodiment habitualized to feminine gender norms constrains our participation in certain activities where "full expression" is predicated upon a masculine norm. Having large-breastedness that generated discomfort as an aspect of their embodiment was something that prevented Joan, Romanda, and Sahar from full expression in particular activities toward some degree of habitualization. For these women, their participation in sport and sex would be possible, but would be both inhibited and permanently non-habituatable due to their bodily motility.

Subsequently, for these three women, the bodily changes provoked by surgery instigated a positive change in the construction and constitution of their body schema. However, one's experience of change in terms of being able to throw herself into running and other sports does not indicate that such uninhibited experiences of the body carried across the range of her lived experience. Romanda indicated that a post-operative infection in her incisions caused severe inflammation that was "really red and visible" and later generated "intense" scarring. This scarring caused Romanda severe discomfort with her breasts that she then brought into her intimate relationships. She said that, "For the next two, three years I was so insecure with any new guy, that [...] I would never take off my bra when I was having sex with somebody new,

because it was like, *I don't want to you see!*" Romanda perceived that her scars made her breasts less beautiful, a sentiment that was informed and reinforced by what she, at the time, thought that the men she was intimate with would think is beautiful. Her perception that her scars were hypervisible impacted how she negotiated intimate encounters with men. Over a period of a few years, though, she came to a self-acceptance of her scars through a series of "discussions" with herself in which she established that she needed "to get over this insecurity with the scars," admitting to herself that *"this is who you are, it's going to be there and it's fine."* Crucially, Romanda's acceptance of her scars enabled her to, as will be discussed below, open herself up to experience sexually pleasurable sensations in her breasts.

Because they felt more "at home" in their bodies, Romanda, Sahar, and Joan were each able to direct the body towards new bodily and embodied possibilities. Moreover, because they perceive that their bodies can engage these activities in a freer or more "open" manner, they now can and do direct the body towards these ends. In this case, even though the modification was one done to women's bodies and not, say, sport itself, breast reduction surgery generated for Joan, Sahar, and Romanda a shift or opening in their sense of embodiment, which in turn engendered the possibility for embodied conditions through which they can fully commit to and "throw" themselves into the physical activities in which they engage.

Shifting Sensations

In addition to creating embodied possibilities that were not there before, and generating a need for bodily adjustments to move the new body through the world, the women I spoke with also talked about new bodily sensations that they experienced as a result of breast surgery. Women categorized these sensations as negative, positive, and/or strange. For example, Leanne

experienced negative affects in terms of bodily sensations both internally and externally, in terms of how her breasts now feel both inside her body and to her touch. Specifically, she said:

When I feel my breasts, all I feel is scars and lumps. So, before the surgery, my breasts felt very soft and smooth. After the surgery and as the years have gone by my breasts feel very lumpy and not soft. It's funny, like, I like the look of them but I don't like touching them for my own self-examination because I don't know what [is] a lump versus a scar. And I don't know if part of that is fear of finding a lump or fear of, *uuuhhh this doesn't feel normal, this feels funny*. [...] I don't like them by themselves. [...] I don't like the feel of them without my bra on.

Leanne expressed that she no longer enjoys how her breasts feel “from the inside” of her body, nor does she like how they feel on the outside, to her touch. Consequently, I asked Leanne if this uncertainty was limited to her experience of breast self-exam. In response, she emphasized that the change in sensation from within and without has left her feeling, in general, like she no longer knows her body as her own. Despite this feeling of alienation, Leanne also experienced a small but positive change in terms of sensation. For example, told me that “immediately after I had the surgery I remember being able to—I'd talk, and breath would hit my chest where I'd never experienced it before. I think because there had been so much breast tissue [removed] that I [now] had a flatter chest and I noticed breath when I spoke. I'd feel it in my chest when I'd never felt it before. [...] I noticed a huge change that way. I couldn't believe the transformation.” The change in the size of Leanne's breasts meant that she was able to feel her own breath against her body, a sensation that she did not experience before surgery. Such a sensation restored, in one sense, Leanne's sense of connectedness to her body, which has been compromised by the change in sensation discussed earlier.

Romanda also experienced bodily change in terms of sensation, and she experienced this change as positive. She described experiencing sexual pleasure from her breasts for the first time, something that happened unexpectedly, and approximately five years after her breast reduction. While it is well known that patients can experience a loss of sensation in the breasts following breast reduction (and augmentation) surgery, Romanda experienced newfound sensation that was pleasurable. “For the first time,” she said, “there was excitement, stimulation, from my nipples. [...] It was so small, and so light, but I was like, *that actually feels good*. [...] I can see what all these women were talking about!” But, as described above, Romanda did not open herself up to the possibility of experiencing this pleasure until some years after surgery, for she was “so insecure” about intimate partners seeing the “very visible” and “not pretty” scarring created by breast reduction surgery.

Leanne, too, described the changes she experienced in terms of the felt sense of the body. Although she described feeling her breath on her chest as a positive experience, she more strongly emphasized a sense of doubt and estrangement in terms of her relation to her body. Leanne knew herself as someone whose breasts were “soft” and “smooth”; she does not and cannot come to know herself as someone whose breasts are “lumpy” and “not soft.” She no longer has a sense of familiarity or comfort with her body explicitly because her breasts do not feel the way that they did before she had breast reduction surgery. Leanne has been unable to accept the new orientation of her body, and she is unable to incorporate this new orientation into her knowledge of her body. Leanne expresses a lack of stability in her felt sense of her body because she has become disconnected from her body to the point that she does not “know” her body anymore. When engaging in breast self-examinations, Leanne struggles to distinguish between healthy breast tissue and potentially pathological tissue. Such examinations depend

upon one's inherent knowledge of the "normal" feel of the breast. But, Leanne is unable to affirm the non-pathological status of her breast tissue because she no longer holds a felt sense of "normal" for her body. The change in the felt sense of her breasts has negatively affected Leanne's perception and therefore knowledge of her body; as a consequence, it has produced a profound alienation that is indicative of a desire for stability.

Similarly, Romanda's description of newfound pleasurable sensation in her breasts indicates a shift in the limits of what is available to the body. In the case of breast surgery, the spatiality and limits of the body change, as was discussed earlier. The scars Romanda has are, as she described them, "not pretty," and this self-evaluation created a significant amount of anxiety for her in intimate relationships such that her refusal to remove her bra during sex was a way for her to engage in intimacy in a way that was more comfortable and less troubling. But, through an explicit and conscious engagement that helped her incorporate her scarred breasts into her knowledge—and eventually acceptance—of her body and its expression, Romanda generated a new sense of bodily stability that allowed for her to experience but, more importantly, enjoy new sensations.

Conclusion

In my conversations with adult women who experienced breast reduction or breast augmentation surgeries, a number of common themes emerged. But, there were also points of contradiction and contention within these themes which suggests a diversity of experiences even where commonalities exist. Several of the women expressed that, pre-operatively, they had a sense that there was a lack of "fit" between their idea of how their body looked or should look and the physical or material reality of their body; this disunity was, for some, what prompted them to undertake breast augmentation or breast reduction. Following surgery, many women

expressed a greater sense of unity in their body, specifically in terms of a greater or stronger sense of proportion in terms of external bodily coherence and a coherence between bodily perception and materiality. Post-operatively, many of the women with whom I spoke were compelled to engage in both discrete and ongoing bodily rehabilitualization and/or spatial reorientation at the same time as they experienced a newfound sense of contentment in and with the body—they had to adjust how they situated themselves in their bodies in order to feel comfortable in and with their new bodily orientation. Many women expressed an expanded sense of embodied possibility, in the sense that a change to the size of their breasts generated by surgical intervention opened up new possibilities for them in terms of what they can do with and feel within their bodies. Many narrated negative experiences and changes, such as pain and dislike of the aesthetic results. Women experienced changes to the appearance of their bodies but also to their feeling of the body from within. As discussed, there was also much variation in terms of how women understood and responded to the embodied effects of surgery: some of these bodily changes were surprising, other changes were anticipated, and still others were unwelcome. Crucially, surgery provided neither wholesale expansion nor restriction of how the body felt or how the body was enacted in and through the world. Instead, the bodily changes instigated by surgical intervention “opened” women’s felt sense and experience of their bodies to myriad responses, sensations, sensorimotor enactments, and possibilities.

The previous chapter established that clinical publications on breast augmentation and breast reduction surgery understand body image as a feeling or attitude toward the body that is determined by the degree of fit and/or congruence between the perception of the body and the material reality of the body. This chapter reveals that the way that women narrate their own pre-operative experience with the body in the interview context indicates that this idea of a degree of

congruence or fit is relevant to women's experiences of their bodies in relationship to their breasts. Women who experience a lack of fit or a low degree of congruence express dissatisfaction with their bodies; this is borne out both here and in the clinical literature examined in the previous chapter. What is more, the women I interviewed who expressed a sense of disunity developed bodily habits such as altering their posture or dressing a certain way in order to generate for themselves a greater sense of unity or to diminish disunity. A more detailed comparison between how clinical publications articulate women's experiences of body image dissatisfaction and distortion and how the women in my study narrate their own experiences of body image will be taken up in the next chapter.

Taking the phenomenological understandings of habit, sensation, and incorporation as grounding concepts, this chapter disclosed how modifications to and of embodiment and corporeality accompany elective surgical intervention at the level of body schema. I explored how and in what ways elective breast augmentation and reduction surgeries provoke a shift in women's conception of the lived body and its possibilities, and galvanizes a process and experience of bodily relearning and ultimately "reworlding." This chapter attends to how surgery changes what the body can do and feel, how the body "operates," and how the body carries the individual through the world. Simultaneously, this chapter attended to how these changes are both lived, felt, and understood by the women with whom I spoke. It concentrated on women's narratives of bodily change in order to think through how the experience of surgery reveals that embodiment is a flexible, contingent, and, ultimately, "open" aspect of experience. To this end, I drew on participants' discussions of expected, imposed, and surprising bodily reorientation(s), the kinds of bodily and mental adjustments that were required in order to move through the

world with a different corporeal orientation, and the ways in which bodily sensations and possibilities shifted or were “opened up” by the experience of surgery.

An engagement with women’s lived experiences of breast augmentation and breast reduction surgery, as narrated by women themselves, is essential to the conclusions that I draw here. Specifically, a focus on women’s stories of breast augmentation and breast reduction, when informed by phenomenology, can focus on the immediate and the affective registers of experience and can also communicate and reveal the idiosyncrasies and peculiarities of experience that cannot be captured with closed-ended surveys and questionnaires. “Lived experience,” as Kruks (2014) writes, “has a reality that is more than a discursive effect” (87). This is not to say that a focus on experience is superior to or presents a more authentic articulation of the realities of female embodiment; rather, it is merely to state that a phenomenologically oriented account of the experience of surgery generates the possibility for different concerns and conclusions. Through an exploration of how women experiences changes to the body and body schema, I have shown that the lived experience of elective breast surgery “opens” embodiment in a way that galvanizes a relearning of the world, a rearticulation of embodied doing, and a renewal of embodied possibility. In the next chapter I synthesize the findings of this and the previous chapter, consider the implications of these findings for the conceptualization of body image and of body schema, and theorize what the competing notions of body image and body schema mean for understanding the relationship between elective surgery and subject formation.

CHAPTER 5: OBJECT BODY, LIVED BODY: THE IMPACT AND IMPLICATIONS OF BODY IMAGE NARRATIVES IN BREAST AUGMENTATION AND REDUCTION

Introduction

The previous two chapters engaged two distinct ways of theoretically and empirically approaching the matter of body image in the context of elective breast augmentation and reduction. Chapter 3 examined, through a feminist poststructuralist lens, publications by surgeons and other health care professionals that took an interest in the question of how elective breast surgery impacts female body image. In Chapter 4, I phenomenologically traced adult women's descriptions of their experiences of elective breast surgery and situated their stories in relation to the lived body and body image/schema. The present chapter takes the preceding two chapters into consideration, and its objective, as a result, is twofold: first, to compare and synthesize the previous findings towards a focused examination of the relationship between elective breast surgery and discursive and lived articulations of body image; second, to think through the significance of these findings for the empirical and theoretical concerns that ground this project.

In the first part of this chapter, I consider what the examination of patient experience of elective surgery reveals about the notion of body image, both when expressed in clinicians' studies as well as when described by patients in their own words. I compare how the narrative about the effects of elective breast surgery on body image changes depending on the discursive context and conditions under consideration. I present some of the reasons why it is productive to simultaneously examine patient and practitioner discourse as co-emergent instead of treating them as distinct investigative objects. I then return to the matter of the distinction between body image and body schema that is advanced in the contemporary phenomenological literature. I

address why it is generative to introduce the phenomenological notion of body image/schema into discussions and studies of body image and of elective surgery. I also return to the tensions over body schema in recent phenomenological literature and reexamine them in light of my empirical findings; I give particular attention to whether my findings support the proposed distinction between body image and body schema, which I introduced in Chapter 2.

In the second part of this chapter, I move beyond the matter of body image in order to discuss more thoroughly the empirical findings against the broader theoretical problems raised in the introductory chapters. I begin by exploring the relevance of a comparative study of how body image functions in accounts of elective breast surgery, in terms of the challenge of theorizing discourse and power in a way that accounts for lived experience (and vice versa); in particular, I return to the presumed tensions between poststructuralism and phenomenology. In addition, I consider the broader implications of the preceding empirico-theoretical studies for our understanding of female bodies, body practices, and embodiment. To this end, in the final section, I consider the broader context of elective breast surgery, and focus on the fact that these procedures are predicated upon a collapse between health and aesthetics and are carried out in the neoliberal biomedical context.

Practitioner Discourse, Patient Narratives, and the “Revealing” of Women’s Body Image(s)

As established earlier, research on body image is vast. Since the 1960s, thousands of studies have been conducted to measure how women in particular perceive and relate to their bodies. The body image literature spans many decades of investigation across a number of disciplines. Body image discourse is now pervasive in popular culture, both in professional discussions of women’s health and in campaigns to improve women’s self-esteem and self-confidence. The case studies conducted for this dissertation project, presented in Chapters 3 and

4, build upon feminist efforts to challenge and change dominant discourses of body image (Blood 2005; Gleeson and Frith 2006), which were introduced in Chapter 2 but are examined below in more detail. On the one hand, this project explored the mobilization of body image discourse in the context of elective breast surgery and, on the other hand, considered the function of body image in patients' first-hand accounts of elective breast surgery.

Chapter 3 analyzed research studies and articles that take up body image in the context of elective breast augmentation and breast reduction surgery, and found that not only does body image function as a discourse, it supports the normalizing effects of elective breast augmentation and reduction. Because clinical studies and articles about elective breast augmentation and reduction reproduce psychology's body image discourse, they reinforce the notion that there is a "correct" way for women to see and engage with their bodies. A woman's internal perception of the size and shape of her body and its parts should correspond with its material reality. When a woman's perception of her body "fails" to align with how her body "really" looks, her relationship to her body is categorized and represented in the literature as pathological. Body image discourse is leveraged to justify elective breast augmentation and reduction surgeries as a legitimate intervention carried out not in acquiescence to aesthetic ideals but rather in the interest of women's psychological well-being. The clinical literature represents elective breast surgery as a psychological intervention, carried out at the level of the self.

When body image dissatisfaction and distortion are identified as the source of women's problems of self- and body-esteem, or when body image distortion and dissatisfaction are presented as an explanation for women's body problems, women are rendered "amenable to regimes of expert advice and corrective treatments" (Blood 2005, 93). In the broader, non-surgical context, treatments for problems of body image include counselling, coaching, self-

affirmation practices, exercise, stress reduction, and healthy eating. The study of clinical publications reveals that elective surgery is increasingly part of this regime and is taken up as a solution to body image problems. In turn, elective breast surgery manifests as a legitimate form of self- and body-care that can “free” women from body image problems. The clinical publications attest to elective surgery’s high rate of success in generating in women positive attitudes toward the body and therefore healthy body image. It is important to note that, in critiquing body image as a concept and a discourse, I do not wish to suggest that women should not want to be or feel content in/with their body, nor am I suggesting that negative feelings toward the body are not concerning. My focus has been to examine how body image functions as a concept in discourses of elective breast surgery from the perspective of both practitioners and patients, to interrogate the implications of a disproportionate focus on body image in this context, to disclose the effects of body image discourse on women’s bodies, body practices, and embodiment, and to propose different ways of capturing and articulating both the impact of elective breast surgery as well as the relationship between embodied perception and material reality.

The fact that elective surgery is presented as a solution to women’s body image problems has additional implications for how women’s bodies are constructed in the clinical and social contexts, given that surgery is an intervention in bodily morphology. Clinical publications communicate that aesthetic surgeons respond to women’s body image problems by bringing women’s bodies in line with “statistically normal” and “proportioned” bodily expression in terms of breast size, shape, and proportion (Botti and Cella 2002; J. Baker et al. 1974; Kreipe et al. 1997; Turhan-Haktanir et al. 2010). Practitioners accept a typical trajectory of female breast development, and their reliance on an idea of what is “statistically normal” creates conditions

that produce body image problems, for the norm is highly restrictive: it favours “proportion” in accordance with body size and pathologizes both excess and lack. Yet, in determining whether their patients and clients have “normal” breasts or breast development, clinicians rely on their patients’ subjective assessments, which means that body image problems, expressed at the level of the individual, and the actions taken to address these problems are privileged over objective measures and over social understandings of how female body image is constructed by social circumstances. I make this point not to suggest that objective measures are or would be more appropriate but rather to indicate that the effect of using patients’ self-assessments to determine problematic breasts is one in which a woman’s perception of and attitude toward the body is taken as a sign and measure of individual pathology, which enables clinicians to disregard the fact that the social and medical construction of “non-normative” bodies as problematic is what might actually construct the identification of pathology.

When a discourse of individual physical and psychological pathology is called forth to account for women’s difficulties with their bodies, the solution to this problem is carried out at the level of the individual. When elective breast augmentation and reduction are presented to women as ways to solve body image problems, the motivation to have surgery is framed as intrinsic to the individual with no recognition of the social context that influences her decision-making process. The clinical publications on body image and elective breast surgery reinforce the notion that women “choose” breast augmentation and reduction “for themselves” and disregard the fact that women’s attitudes towards their breasts are not formed in isolation from cultural or social influences. Although, as noted earlier, clinicians and health care practitioners acknowledge that social and cultural expectations for female bodies are rigid and unrealistic, this awareness has no bearing on how clinicians interpret women’s initial motivations for surgery or

feelings about the results of surgery. Moreover, the studies themselves, managed by clinicians and grounded by questionnaires and surveys, also do not occur in a vacuum; they are a “social practice which reproduces women’s bodies/subjectivities within gendered power relations” (Blood 2005, 37). To be specific, the survey and questionnaire mechanisms that comprise the clinical publications support women’s engagement in practices of self-surveillance because they ask women to scrutinize the size and shape of their breasts and bodies; in the clinical encounter, surgeons themselves also engage in these observations and practices. In turn, a peculiar phenomenon arises wherein the route to body image transformation—characterized by a supposed freedom from body scrutiny—is necessitated by women’s engagement in self-objectification and in the clinical evaluation of this self-objectification.

Yet, what practitioners neglect to admit is that the socio-cultural context largely determines clinicians’ orientation toward female breasts and bodies; subsequently, this context informs how surveys are designed, how women are expected to respond, and how the “diagnosis” of body image distortion or dissatisfaction will then be understood and managed. Clinicians take women’s responses to questionnaires as a valid and accurate reflection of their “problems” without due consideration of how the body image frame might elicit a certain response or how widespread social discourses of female bodies and body image problems might also produce certain interests. Certainly, aesthetic surgeons have a vested financial and professional interest in securing patients; connected to this, they have a stake in acquiring and publishing results that statistically support and validate the procedures that they perform. However, health care practitioners’ espoused investigative and clinical commitment to the impact of elective surgery on body image endorses invasive surgery as a sensible solution to issues of self-esteem and body confidence.

Therefore, the reproduction of body image discourse in clinical publications about elective breast surgery functions to support elective breast augmentation and breast reduction as legitimate and statistically verified ways to manage problematic relationships between mind and body. Studies of elective breast surgery that focus on outcomes related to body image communicate findings that—drawing on the empirical legitimacy and social currency of body image—can connect elective surgery with a commitment to the development of good psychological health and individual well-being. When studies demonstrate that elective breast augmentation and reduction have a positive effect on a patient’s psychological well-being, aesthetic surgeons and health care practitioners can express their commitment to health and more importantly to women and, at the same time, diminish the critique that their work encourages conformity to established aesthetic and/or morphological norms.

As noted earlier, even when clinical discourses of elective breast surgery focus on women’s body image and purport to be acting in the interest of women’s health, they do not offer women’s descriptions of their lived experiences. The questionnaires and survey instruments that form the basis of pre- and post-operative examinations of how breast augmentation and breast reduction affect women’s body image are quantitative measures that do not and cannot account for bodily or experiential idiosyncrasies. In this sense, the studies are structured in the same manner as seminal body image research, in that they aim to solicit women’s subjective experiences through objective measurements such as closed-ended surveys and questionnaires. Such research tools “have already predetermined what counts as meaning” in relation to body image and they “only permit certain—predetermined—responses” (Blood 2005, 34, 17). In the clinical publications, the “forced-choice questions elicit particular responses [and] the responses inevitably are going to fit within the assumptions and the ‘knowledge’ already produced within

the theoretical frames of the researchers...and will necessarily reinforce those findings” (Blood 2005, 19). As discussed in Chapter 2, phenomenological inquiries of biomedicine have long critiqued biomedicine for its emphasis on objectivity and subsequent elision of patients’ lived experiences. My findings suggest that as much as the health care practitioners who perform and support elective breast reduction and augmentation claim to be doing so in support of women’s well-being, their understanding of how to address these issues that is based on what can be ascertained through women’s responses to closed-ended surveys and questionnaires.

Because the clinical publications offer such a partial engagement with women’s pre- and post-operative experiences of elective breast surgery, it is important to not only trouble but also complexify these accounts in order to challenge the normative production of truth and the institutional regulation of female bodies. The analysis of clinical discourses on elective breast surgery accomplishes this by demonstrating how such studies and articles not only communicate a standardized narrative of women’s bodies and bodily experiences but also champion performing invasive procedures that implement corporeal norms. But, another way to challenge the dominant account of female body image in the context of elective breast surgery is to counter the predetermined outcome of the clinical studies by soliciting thick descriptions of these same experiences from patients themselves.

Here, phenomenology, with its emphasis on direct descriptions of our experience as it is, engenders the possibility to account for the lived and social world of the individual in the constitution of identity and embodied experience. I solicited women’s narratives of elective breast reduction and augmentation in order to consider what their narrativized experiences might reveal about female body image and female embodiment, against what is presented in clinical studies of this same population. The phenomenologically informed investigation of women’s

experiences disclosed women's first-hand accounts of their experiences of elective breast surgery in a manner that can also broaden the understanding of body image, due in particular to the long-standing presence of body image/schema in the phenomenological literature.

The conversations that I had with women about their experiences with breast augmentation and breast reduction surgery generated a number of phenomenologically relevant findings. Women talked about feeling a sense of bodily incongruence before having surgery and a greater sense of bodily proportion after. They discussed a number of changes in how they interacted in and with the world through their bodies, in that the bodily change brought on by a reduction or enlargement of their breasts subsequently instigated a rehabitualization of the body and adjustments to their understandings and enactments of the body in space. At the same time, bodily change also generated in women an expanded sense of what they could do with their bodies and, in turn, a broader range of bodily experiences. Body change also initiated shifts in the felt sense of the body in terms of bodily sensations.

There emerged many parallels and points of convergence with respect to what women expressed as their respective motivations for surgery and what was discussed in the clinical literature. For example, women who had breast reduction surgery did express that chronic pain and physical discomfort influenced their decision to have surgery; this motivation is also documented in the clinical publications. Yet, pain and discomfort were never the sole motivating factors for women seeking breast reduction, which is also identified in clinical publications. Some women were motivated to seek breast reduction or augmentation surgery because tangible changes in the size and/or shape of their breasts—including weight loss, weight gain, health changes, pregnancy and/or breastfeeding—changed their relationship with their bodies. Experiences such as these are not accounted for in the clinical literature even though they formed

in the interviews a significant part of women's breasted experiences. This confirms that perceptions and attitudes towards the body are a basis for motivation toward surgery, but it also reveals that women are not solely motivated by aesthetics or by a certain perception of bodily inadequacy and that material changes can provoke a shift in one's relationship to the body.

What is also interesting, in terms of the comparison between clinical publications and women's first-hand accounts, is how differently women themselves describe the outcomes of elective breast reduction and augmentation. My analysis of clinical publications found that when post-operative results are discussed, the focus is solely on positive outcomes that demonstrate a favourable shift in body image, which is marked by reports of improvements in self- and body-confidence, happiness levels, satisfaction with appearance, social and intimate relations and of reductions in anxiety, embarrassment and/or self-consciousness. Clinical publications do not report on setbacks or negative outcomes, except, it is worth pointing out, in cases where patients experience complications and return to surgical care. In contrast, women's accounts offered far more nuanced descriptions of outcomes. As noted in Chapter 4, some women experienced a sense of alienation from the body. Some indicated that the body felt different from within and without, which made it difficult for women to feel that they "knew" or were "at home" in their own bodies. Others felt that, even after breast reduction surgery, their breasts were still too large and thus they still experienced discomfort in and with their bodies. Some were deeply troubled by the degree of scarring that became a part of their breasted experience. Importantly, many expressed a similar, pre-operative feeling of alienation and discomfort. While many aspects of women's experiences can be categorized as positive outcomes, women also described many adverse aspects of their experiences. The "outcomes narrative" in most cases is not, as clinical publications would have it, a perfectly linear one in which women transition from an experience

of negative to positive bodily image. To point this out is not to suggest that clinical publications misrepresent women's experiences; instead, it is to suggest that the interests and design of clinical studies combine to produce an outcomes narrative that is oriented around transformation. In contrast, when women communicate their experiences in less encumbered circumstances, a broader and more complicated narrative emerges, which suggests that not all outcomes are exclusively positive or transformative, and that positive and negative outcomes coincide in the same experience. It also suggests that women's post-operative outcomes are not always marked by transformative experiences that perfectly map onto their pre-operative counterparts.

Another aspect of women's experiences with elective breast surgery that emerged in first-hand accounts but that is not accounted for in clinical publications is that of bodily movement and action, which is as central to our experience of the lived reality of the body as its appearance. As discussed in Chapter 4, women described a range of changes in their experience of the body as the conduit through which they engage in the world. Women described a range of adjustments, but they also noted that the change in their bodily orientation subsequently changed what they thought and felt that their bodies were able to do. Some experienced a shift in the nature of their relationship with sport, while others engaged differently in their intimate encounters. Although clinical publications do make mention of changes in women's enactment of the body, noting in a few instances that, post-operatively, women engaged more freely or readily in physical or sexual activity, the overarching emphasis is on measurable shifts in women's feelings about appearance and psychological well-being. Clinical publications are not actually set up to consider how women are *in* their bodies. In contrast, women's first-hand accounts of their experiences of bodily change through elective breast surgery capture how

surgery changes how women are *in* their bodies and how it feels to *do* and enact the body in the world.

Therefore, a number of points of overlap and divergence are revealed when the discourse of clinical publications on elective breast surgery is compared with women's direct descriptions of these same procedures. The above synthesis suggests points of interception as well as discrepancy between clinical publications and women's narratives in terms of the major empirical findings of the previous two chapters. In the sections below, I consider the broader implications of these findings in terms of the research questions that orient this dissertation project: the nature of the production of body image, the relationship between body image and body schema, and the interconnections between discourse and lived experience in understanding the body, embodiment, and body practices.

Connecting Patient and Practitioner Perspectives

It is important to consider why it is and has been productive to engage in a study that takes up clinical practitioner *and* patient discourse, particularly because this project mobilized poststructuralist theory, which is critiqued by feminist theorists and critics of biomedicine for its ignorance of lived experience, alongside phenomenological inquiry, which is critiqued by feminist theorists and critics of biomedicine for its inadequate theorization of power relations. A primary objective of this study was to, in the context of elective breast augmentation and reduction, concurrently consider the operation of discourse and lived experience as a way to generate new conceptual possibilities for understanding and exploring given discursive and lived phenomena. The above discussion has merely gestured toward the intersection of discourse, lived experience, and power; I return to this matter later on in this chapter.

There are many reasons why it is productive to analyze health practitioner discourse at the same time as we create opportunities to disclose patient narratives. Notably, studies that consider in tandem practitioner and patient narratives are rare: the majority of investigations of elective surgery typically consider one or the other narrative. For example, poststructuralist engagements of women's health tend to be critical of the discursive and power effects of biomedicine but they do not attend to the lived experiences of women who experience the practices in question to see how these effects are borne out in the everyday (e.g., Bordo 1993; Morgan 1991). Phenomenological critiques of biomedicine engage patient narratives for the purpose of recovering the patient experiences elided in the clinical setting, but they generally do not contain an account of practitioner discourse or a sustained analysis of the conditions under which these procedures are carried out (e.g., de Boer, van der Hulst, and Slatman 2015; Slatman et al. 2016). This emphasis on biomedical discourse in the first instance and patient narratives in the second instance does not necessarily represent a methodological shortcoming but is rather a testament to the respective investigative and theoretical foci of these theorists. Analyses that simultaneously consider patient and practitioner narratives can complexify our studies of female bodies, body practices, and embodiment by, in the present context, analyzing how body image research perpetuates conditions in which women see themselves as objects and disclosing how women come to live as embodied rather than object beings in a social world preoccupied with female body image.

Given the paucity of accounts that consider practitioner discourse alongside patient narratives, it is important to explore what has been revealed in this project's simultaneous consideration of the discourse of practitioners of elective breast surgery and the narratives of women who have undergone these procedures. The empirical findings of the previous two

chapters can be brought into dialogue with one another in order to think through what is revealed when we consider the clinical discourse of elective breast surgery alongside women's first-hand accounts of elective breast surgery.

First, patient narratives, as much as they can be linked thematically, are not entirely analogous with one another. Although there are many points at which patient experiences overlap, the particularities of these experiences are diverse, whether the conversation is about pre-operative motivations for surgery or post-operative experiences of bodily change. For example, several women were motivated to undergo breast augmentation surgery as a way to feel more feminine; however, each had a different idea of what constituted femininity. Clinical publications draw on closed-ended surveys that only allow participants to respond in the affirmative or negative, denying the possibility of elaboration or indeterminacy. There is thus an idiosyncrasy in patient narratives—and, by extension, experience—that cannot be captured by questionnaires and surveys that contain no possibility for elaboration. As a result, when women have the opportunity to narrate their experience, a much richer and more diverse account of the effects of elective breast augmentation and reduction can emerge, although the narration of that experience is of course produced in discourse and guided by the semi-structured interview process. As seen in Chapter 4, interviews generated the conditions for nuanced and discrete accounts of experience; women's experiences were at one and the same time positive, negative and neutral, and people responded to the same outcomes in vastly different ways. In addition, some women with excessive scarring following breast reduction surgery were not bothered by their appearance whereas scarring was a great source of distress for others.

Interviews also facilitated the expression of changes in women's perspective and attitudes towards the body—some things that were troublesome or negative aspects of bodily change

became neutral or positive over time, and vice versa. These are manifold and nonlinear narratives that contrast the linear, homogenous one presented in clinical publications. The linear narrative arc, rendered legitimate by surveys and questionnaires, is presented as a valid testament of the benefits of elective breast surgery; there is no acknowledgement of dissatisfaction or of the way that a beneficial experience might be constructed by the survey mechanism. Moreover, it is worth noting that although each interview participant was generally satisfied with her results and was happy she elected to have surgery, only one participant's experience directly aligned with the body image narrative espoused in the clinical publications (even though the interview protocol made it possible to communicate such a narrative, in that it asked participants if they were satisfied with their results (see Appendix 1)).

At the same time, there are points of overlap between the results presented by the clinical publications and the interview narratives. The publications and interviews contain similar motivations for undergoing breast augmentation or reduction. In clinical publications, we are told that women feel that their breasts are too small, too large, or out of proportion with their bodies. This experience of the body also manifested in the interviews as a motivating factor for women. However, in the interview setting, women offered additional details about how a lack of fit or feeling of disproportion affected them in the everyday, which is something that is not and cannot be accounted for in clinical publications. Women described to me feelings of being uncomfortable in and/or with their bodies. This discomfort took the form of a felt sense of being uncomfortable in space as a result of the body's orientation but it also meant discomfort in terms of perception of the body, in that the material body was felt as misaligned with how women thought their bodily materiality ought to be expressed. In contrast, clinical publications can only affirm that this feeling of lack of fit—typically expressed in the latter sense—exists. Therefore,

while there is some overlap, the interviews allowed for the expression of idiosyncrasies that closed-ended surveys, oriented by the dominant discourse of body image, cannot capture.

Furthermore, while there is some degree of overlap in women's experiences of body image as they are expressed in clinical publications and in semi-structured interviews, women's accounts present unique aspects of experience not present in the clinical publications. Certain motivating factors are not interesting to and are thus not present in the clinical publications. Interviews have the capacity to disclose not only a broader range of experiences but also multiple experiential trajectories. For instance, in the clinical literature, the overarching narrative was one of personal transformation, in which elective breast surgery generated positive body image in patients and improved their relationship with their bodies. This trajectory did not manifest as readily in the interview setting. Although all of the interview participants were typically content with their decision to have surgery as well as with the results of their surgery, they did not especially emphasize aesthetic appearance when discussing outcomes.

Overall, a comparative exploration of clinical publications about and women's first-hand experiences of elective breast surgery is but one way to explore how the embodied subject is affected by biomedical intervention. Feminist and phenomenological critiques of biomedicine often focus on the way that biomedicine directs its interventions at physiological or biological causes particularly because biomedicine views the body-subject as a machine to be fixed. At first glance, the focus on patient psychology in relation to body image in the clinical publications on elective breast surgery appears to be a productive shift away from aesthetics. Clinicians' emphasis on women's psychological well-being communicates that the impetus for carrying out breast augmentation and reduction is not just about improving the aesthetic appearance of women's breasts and bodies but is actually and primarily about improving women's relationships

with their bodies so that they can be psychologically healthy and socially active and productive. In this way, a clinical emphasis on body image appears to complicate not only the reason for surgical intervention but also the terms under which outcomes are evaluated. The clinical publications, in their interest in body image, appear to focus on women as embodied subjects rather than as mechanical objects. But, discursive analysis of these clinical publications revealed that, even though there is an emphasis on women's body image and psychological well-being, a biomedical solution is still offered. What's more, women's pre- and post-operative experiences of body image are solicited through the use of measurements that cannot capture the subjective or idiosyncratic aspects of experience. One effect of this is that clinical publications report solely on aspects of experience that can be categorized and systematized; in turn, women's experiences of body image are appreciable to the point that they can be objectively recorded, measured, analyzed, and resolved.

Body Image and Body Schema: Reconsidering the Distinction

It is also important to return to the conceptual tensions between body image and body schema in contemporary phenomenology and to contemplate what the findings of this project contribute to this debate. As noted, much of the recent work in phenomenology supports a conceptual distinction between body image and body schema, upholding a framework in which body image marks our conscious system of action and perception, while body schema reflects the pre- or non-conscious, neurological organization of the body (Gallagher 2005; Gallagher and Zahavi 2013; Slatman 2007; Taipale 2014). For phenomenologists who support a distinction, body image represents not only our conscious feelings about our bodies but also our conscious awareness of our body's engagement with the world. In contrast, body schema represents the

biological and neurological processes that support our bodily movements and existence but that are not cognitively available to us.

Women's first-hand accounts of their experiences of elective breast augmentation and reduction surgery offer a number of insights into the matter of whether body image and body schema manifest as discrete yet interrelated entities. Women's narratives, as demonstrated in the preceding chapter, emphasize an inseparability of mind, body, and world, which is not emphasized as such in the clinical literature. The study of women's lived experiences of bodily change in breast surgery reveals that the body schema is "not merely an experience of my body, but rather an experience of my body in the world" (Merleau-Ponty 2013, 142). Women's discussions of proportion and balance, for instance, are suggestive of what Merleau-Ponty established as the indivisibility of the body and its parts and, subsequently, the inseparability of the body with the world. The experience of the body as a unity that is lived-through points out that the body schema can only be shown and understood in terms of its possibilities, because the knowledge of the capacities of the body are a form of knowledge that is pre-conceptually sedimented in the lived body (Fielding 1996). In turn, the body schema cannot be understood as an experience of spatiality that exists solely in the realm of figures and points, given that "we move our phenomenal body, not our objective body" (Merleau-Ponty 2013, 108).

Overall, women's experiences of breast augmentation and breast reduction surgery reveal, as presented here, that the body schema connects with the structure of embodied consciousness. The body schema is an awareness of both posture and the "functionality of [the] body as being-in-the-world" (Levin 2008, 53); it marks an awareness of where the body is in the world and a sense of what the body can accomplish while situated here. This twinned awareness of posture and function affirms one's subjectivity *as* body ("I am my body") and allows an

individual to carry out and realize projects in, through, and with the body. In communicating and thinking phenomenologically through women's lived descriptions and experiences of surgery, it is revealed that the body schema is at once a psychological, social, and physical system that serves, in part, as the epistemological basis for our agency in lived experience.

In this case, then, the body schema is not merely the mental representation of the body and its parts, as is understood by the clinical discourses. Understanding the body schema solely as a representation privileges consciousness as that which structures our embodiment. The body is flexible, fluid, sinuous, and capable of adapting to new realities and experiences through habit and without the express participation of consciousness (Fielding 1996; Levin, 2008; Merleau-Ponty 2013; Schilder 1950; Weiss 1999). We must generate space for the body schema to be an aspect of experience that we might cautiously term psychosomatic, given Merleau-Ponty's rejection of Cartesianism and his affirmation, informed by Schilder but also Marcel, of the unity of mind and body. Merleau-Ponty's phenomenology, as established earlier, affirmed the interconnection between mind and body. The central feature of Merleau-Ponty's phenomenology is his attention to consciousness as embodied and to the body as integral to our perception of the world. Most famously, he critiques traditional psychology, for instance, for perpetuating a dualism between mind and body that positions the body as a mechanical thing with no inner life, the experience of which can only be represented as psychic fact. Merleau-Ponty attends to and re-centres the body so as to reunite the "soul" with the body from which it has become alienated, to demonstrate that the body is not merely a physical entity or object, and, perhaps most importantly, to affirm that the body is essential to and for being-in-the-world.

If we account for and follow the interconnectedness of consciousness and embodiment, as is demonstrated in women's embodied experiences with surgically induced bodily change, the

importance of a conceptualization of the body schema that parallels and incorporates this premise of interconnectedness is revealed. The body schema, like the body itself, is an “ambiguous” mode of existence. If the body reveals our “ambiguous mode of existing,” wherein we are neither purely object nor purely consciousness (Merleau-Ponty 2013, 204), then the body schema must function in a similarly ambiguous manner given that the body schema is the means by which I “have” my body (Merleau-Ponty 2013, 142). The body schema should be understood not as an unchanging or closed “summary” of our bodily experience with respect to position, movements, or stimuli, but as an open and fluid system functioning in a consistent interaction between bodily movement and embodied recognition of and reflection upon embodied movement. Such a move, in relation to the descriptions offered by women who have had breast augmentation or reduction surgery, restores and re-centres the phenomenal body. Such a move also restores, in an exploration of embodiment, the “fluidity, sinuosity and motility of our bodily capacity” (Fielding 1996, 250), the body as experience, and a discussion of bodies that are always in and toward the world.

The results of the phenomenological inquiry into women’s experiences of elective breast surgery suggests opposition to a conception of the body schema as a pre-cognitive system comprising “dynamic motor equivalents that belong to the realm of habit rather than conscious choice” (Gallagher 2005, 21). Conceptualizations of body schema that advocate for this system as a purely pre-cognitive phenomenon generate the implication that the body can be its own agent, determining motility and posture with little intervention of or participation from consciousness. Instead, the body schema is a system that includes and relies on both pre-cognitive and cognitive physical awareness: habit with consciousness; motility with awareness. The body’s movements become significant and meaningful when accessed by consciousness.

Merleau-Ponty's reading of the body as unity shows that our bodily doing and embodied being in the world is never solely physiological; in turn, the body schema can be thought of as a sinuous amalgam of consciousness- and body-activity. When we position Merleau-Ponty's articulation of mind-body unity in terms of body schema, the body schema becomes neither exclusively intentional/conscious nor exclusively mechanical/non-conscious, and this composite is borne out in the lived experiences cited earlier.

To posit a model of body schema that presents it as distinct from body image, as Gallagher (2005), Carman (1999) and Slatman (2007) advance, is to separate our conceptual understanding and perceptual experience of our body from the physiological and neurological processes that regulate our movement and render these as discrete elements of embodied experience that function in isolation from one another. To advocate for a conceptual distinction between the non-cognitive movement and posture on the one hand, and the personal relation to the body on the other hand is to discount the intimate coordination between movement and awareness in actual, embodied experience. Further, to present the body schema as a set of impersonalized motor skills and/or capacities that are ultimately non-cognitive and disassociated from our awareness is to create a kind of "closed" understanding of embodiment, which is not receptive to the manner and extent to which embodiment is literally and figuratively "open" to new possibilities that are cognitively felt and physically enacted, and generated explicitly by an intertwining of self-representation and motor function.

Lived Experience in/as Power

The primary theoretical aim of this project has been, as noted above, to combine poststructuralist and phenomenological inquiry in an examination of the relationship between elective breast surgery and body image. My purpose has been to in part offer a critique of the

conceptualization and mobilization of “body image,” but more so to further develop our conceptualization of the discursive and phenomenological effects of elective breast surgery in relation to body image. In the introductory chapters of this dissertation, I elucidated upon the tensions that have been articulated between poststructuralism and phenomenology, and worked through contemporary theoretical inquiry that indicates that these two theoretical frameworks are not only compatible but that they can in fact be drawn together to offer richer accounts of the body, body practices, and body experience. At this point, it is crucial to return to the supposed tensions between phenomenology and poststructuralism and consider these tensions anew in the context of the empirico-theoretical findings of the previous two chapters. To this end, I will attend to the aforementioned tensions between power, discourse, and lived experience specifically in light of the poststructuralist analysis of clinical discourses and in the phenomenologically oriented disclosure of women’s narratives.

Feminist philosophers in particular have established the possibility of and advocated for the interweaving of poststructuralism with phenomenology. Because they recognize that an interplay between structures of power and experiences of agency is often a defining feature in women’s lives under patriarchal power, feminist theorists suggest bringing phenomenology and poststructuralism together in making sense of the intersection of experience and mechanisms of power in women’s lives. Many feminist scholars advocate for the pairing of poststructuralism and phenomenology (Cosgrove 2001; Stoller 2009, 2010) and have emphasized that these frameworks can and ought to be knit together in the study of women’s body and beauty regimes (Dolezal 2010; Levin 2008; Heyes 2007a). Writing about women’s desire to achieve a “normal” body—one that disappears from notice or is invisible—Luna Dolezal (2010) encourages feminists to bring phenomenology and poststructuralism into dialogue with one another so as to

yield richer accounts of women's engagements with aesthetic surgery. A phenomenological framework can reveal that women participate in these systems "in order to facilitate their daily existence in the world through an augmentation of social capital and power, resulting from a mastery of body aesthetic and comportment," and a poststructuralist perspective can identify the "mechanisms behind the drive for normalization of the body for contemporary women" (Dolezal 2010, 370, 372). From this perspective, a dual framework generates the possibility for a nuanced engagement with elective surgery that not only resists exclusively representing elective surgeries as homogenizing and normalizing interventions but also refuses to solely position engagement with these procedures as an exercise of agency.

It is important, then, to think through how a poststructuralist-phenomenological account of the effects of elective breast surgery on body image, informed by feminist theorizing on the body, opens up the possibility to think through the discursive *and* lived implications of these procedures. Bringing together these two frameworks in order to make sense of the relationship between elective breast augmentation, breast reduction, and body image generates several, meaningful insights that speak to the tensions between power and lived experience. In this context, the dual framework enhances our understanding of the objective and subjective constitution of the subject, and it turns our attention to how bodies and subjectivities are concurrently shaped by power *and* experience. Ultimately, this dual framework can attend to the ways in which the ongoing subjection to disciplinary mechanisms and the experience of acting with intention are concurrently present in the individual and thus not incompatible, practically or theoretically speaking.

A poststructuralist-phenomenological framework, attuned as it has been in this project toward the relationship between body image and elective breast surgery, can generate insights

into the ways in which subjects are both constituted and constituting. The constitution of the subject by discourses and institutions of power is supported by the analysis of clinical discourses of elective breast augmentation and reduction. Such publications act as a document of how surgeons and other health care practitioners impose the rules of normalization upon female breasts and bodies and produce docile bodies, recommending surgery to “correct” body problems. In these studies, articles, and editorials, health care practitioners affirm their allegiance to an “optimal model” of female breastedness and female body image: there is a suitable size and shape for the female breasts as well as an appropriate relationship for women to have with their bodies. The studies examined in this dissertation comprise a published record of how practitioners analyze and classify individual bodies, body parts, behaviours, and attitudes against established objectives and propose discipline through surgery as the way to get individual women’s bodies—through the production of aesthetically appealing breasts—and conduct—through the transformation of body image—to adhere to optimal models of aesthetics and disposition. Certainly, individuals make the choice to undergo these procedures, and so their motivations as well as their perception of outcomes will be actively and strongly shaped by disciplinary and normalizing practices: “the female subject, in her efforts to fulfill the social expectations for her body, renders herself an anonymous, normalized subject” (Dolezal 2010, 357). Put another way, elective surgeries eliminate bodily diversity in favour of the production of homogenized aesthetics and attitudes.

As much as women “choose” to have surgery, surgeons’ commitment to the elimination of bodily diversity, marked as deviance and pathology, in combination with the routinization and systematization of the procedure itself, indicates that outcomes will be homogenous and that the

technology of surgery will be undetectable.³⁵ The present project has also focused on how elective breast surgery is positioned as relevant to the treatment of body image problems and demonstrated that this is also a case in which surgeries that produce homogenous bodies are also positioned as a legitimate intervention in body image. The normalizing effect of this move is that it generates individual conduct and behaviour that is in accordance with accepted standards. Therefore, in both instances, disciplinary and discursive mechanisms operate to produce subjects who are complicit with agreed-upon codes of appearance, attitude, and conduct. When we analyze, through a feminist poststructuralist lens, clinical discourse that takes up body image, we can affirm that body image works alongside elective surgery as a mechanism of power that objectifies women to support the production of docile and compliant subjects.

At the same time, because individual women opt for surgery of their own volition, it is crucial to acknowledge their experiences and stories, given that clinical publications are not, as established in this chapter, interested in the depth of women's motivations or experiences. A phenomenologically oriented inquiry, which necessitated attention and attentiveness to women's narratives of their experiences of surgery and its effects on their embodiment and subjectivity, signifies that working to account for the body-as-lived enables the identification of outcomes and effects that are particular and cannot be categorized as homogenous. Although changes to body image/schema emerged along the same axes of bodily and embodied experience, there were numerous idiosyncrasies within these experiences. Crucially, women's identifications of the process of dissolution and rebuilding of the body schema marked distinct and differentiated experiences. For example, some women identified that, post-operatively, they express their bodies differently in intimate relationships, yet this expression took discrete forms: there were

³⁵ The projected and ideal outcomes of elective breast augmentation and reduction parallel the outcomes of more recently developed elective procedures, such as female genital cosmetic surgery (Braun 2009a; Tiefer 2008).

manifestations of more reticent alongside more manifold participation in intimate encounters. In addition, some described changes to their embodied relation to physical activity. For some, this meant newly participating in physical activities; for others, this took the form of renegotiating their embodied doing such that they could continue participating in the sports that they liked.

Addressing how elective breast surgery impacts how women live in the world through their bodies and bodily capacities, instead of focusing solely on how women live in the world in relation to their appearance, offers a different way of conveying how our being is wrapped up in our embodied experience and our subjectivity, because the rebuilding of the body image/schema is complemented by reimaginings of bodily intentionality and capacity and recreations of how women apprehended the world through their bodies. The findings of the phenomenologically oriented study of how the body change instigated by elective breast augmentation or reduction affects individual women at the level of embodiment communicates that elective breast surgery is an experience through which women can actively rebuild and reconstitute their body images/schemas. Turning our attention to the body-as-lived opens the possibility to think through how our subjectivity is constituted via the way we live in the world through our bodies, particularly because it provokes an engagement with how elective breast surgery changes how the body carries us through the world.

Furthermore, because elective breast augmentation and reduction are caught up in idealized aesthetics and the standardization of healthy body image, these surgeries impact the way that women participants come to view themselves. For instance, the decision-making and consultation processes that precede surgery perpetuate women's participation in self-objectification. Women considering surgery observe, analyze, and critique their bodies, both on their own and in consultation with their surgeons, towards participation in body work via

surgical intervention. When negative body image is introduced into the surgical context and becomes a determinant of candidacy and suitability, body image discourse also inculcates women into processes of self-objectification and self-surveillance. This occurs along physical and psychological planes: women examine their bodies against normative feminine morphology and are invited to consider their attitudes towards their bodies in the face of this morphology. Women internalize socio-cultural ideas of proper breast size and shape and of bodily proportion in relation to their breasts, and then engage in processes of self-objectification in which they account for their bodies and their body images on the basis of these socio-cultural determinants of acceptability. The perpetuation of fraudulent, aesthetic ideals in conjunction with the rise of body image norms come to determine how women view themselves and produce for women particular subjectivities with which they can identify, therefore revealing how female subjectivity is actively shaped through power relations.

When phenomenology is introduced to consider the impact of elective breast surgery on female body image/schema, it facilitates an engagement with how women see themselves and their bodies. In their accounts of how they live through bodily change after elective breast surgery, women certainly offered descriptions of changes to bodily appearance and aesthetics, and many women were motivated to have surgery for these same reasons. In turn, women who offered their first-hand accounts of surgery were not immune to processes of self-objectification, whether pre- nor post-operatively. Several women described that they were happy with the aesthetic appearance of their breasts following recovery, and often described this in relation to the sense of fit or proportion to the body as a whole. At the same time, conversational trajectories about appearance opened up room for women to account for themselves along axes distinct from aesthetics. The above-mentioned articulation of changes in bodily capacity and possibility is but

one example. To return to a different example, sensation was a significant aspect of how women came to regard themselves after breast augmentation or reduction. Some participants who were satisfied with the aesthetic appearance of their breasts were still uncomfortable with and alienated from their bodies because of how their breasts felt to the touch; others were distressed by how scarring changed their breasted aesthetics in what they perceived as a negative way, but they were happy to experience newfound sexual pleasure in their breasts. Women's attunement to matters of sensation and bodily expression, therefore, signal more than simply a preference for a particular aesthetic; it also marks an involvement with the body that is oriented around the felt sense of the body, as distinct from aesthetics. In sum, first-hand accounts, solicited through a framework attuned to the lived body, offer descriptions that account for other aspects of experience besides whether or not one's breasts do or do not fit within the socio-cultural limits of bodily acceptability.

Ultimately, a poststructuralist-phenomenological framework is one that can attend to bodies rendered surface *and* bodies in their depth. When the dominant discourse of body image is leveraged in survey- and questionnaire-based studies to validate the surgical production of psychological well-being, surgical intervention is oriented around bodies in their objective being. Objectified bodies, marked as they are through empirical testing, identification as defective, and projected suitability for repair, can be inscribed by the normalizing knives of surgical intervention. What is unique to this particular context is the way that the patient's "subjective" experience is in fact taken into account, but similarly objectified and rendered an appropriate target for surgical intervention. In contrast, leveraging the notion of body image/schema in conversations with those who have lived through elective breast surgery, engenders the possibility to account for bodies in a manner that begins to account for its depth. Narrative

accounts of elective breast augmentation and reduction are ambivalent, discrete accounts of attentiveness to and awareness of articulations of the body in its situatedness. A framework that aligns poststructuralism and phenomenology contains the potential to manifest given phenomena as simultaneously discursive and lived.

These productive points of theoretical intersection and conceptual overlap establish that it is constructive for feminist empirical and theoretical research to more regularly think through contemporary social and cultural phenomena by bringing together poststructuralism and phenomenology. Focusing on the interplay between power and lived experience in the context of elective breast surgery and body image simultaneously attends to the body-as-such and the body-as-lived and contributes to our understanding of bodies as thoroughly discursive *and* phenomenologically lived (Levin 2008). Although the literature on female bodies, body practices and embodiment often contains this tendency, feminist theory benefits from accepting women's position as dually interpellated by disciplinary mechanisms and being in the world with intentionality: this position can offer fuller, more comprehensive, and more nuanced accounts of the oppressive and liberatory aspects of female embodiment and lived experience. It asks feminist theorists concerned with life in/under power, to identify the sources of women's oppression and to acknowledge women's lived experiences as those that evade, ignore, comply with and resist such structures. Knitting together these two frameworks forces an awareness of how women come to be "surgical subjects," in the double sense of the term, because it opens up possibilities to consider how we live our bodies and how we live as subjects in a milieu in which power relations manage bodily process and subjectivities.

Aesthetics and Health in Elective Breast Augmentation and Reduction

In the introduction to this dissertation I proposed that, in the context of elective aesthetic surgery, ideas about health and aesthetics intersect to the point that they envelop one another. I suggested that elective breast augmentation and reduction, despite being thought of as categorically distinct procedures with different objectives, instigate a slippage between health and aesthetics specifically because they are carried out in a clinical setting on a bodily site primarily valued for its aesthetic qualities and its associations with womanliness and femininity (Barina 2015; Jacobson 2000; Young 2005). Although this project has, to this point, focused on the impact of elective breast surgery on body image, the fact that an elective surgical procedure attuned to aesthetics is carried out in the interest of women's psychological well-being suggests that it is important to consider more closely the intersection of health and aesthetics in this particular surgical context.

Recent critical engagements with biomedicine and health care have critiqued the ways that discourses of health regulate our bodily morphology, expression, and practices. As much as health is a desired state, it is also a "prescribed state and an ideological position" (Metzl 2010, 1-2). It is used to make moral judgments, to convey prejudice about certain bodies and towards certain practices, to turn people into patients, to sell products, or to introduce people into "care" regimes. Health care recommendations, positioned as healthy in and of themselves or carried out in the name of health, can "seamlessly construct certain bodies as desirable while relegating others as obscene" (Metzl 2010, 3). The case of breast augmentation and reduction is bound up in ideological notions of both breast appearance but also of individual and social attitudes towards the breasts. This is espoused in clinical publications on breast augmentation and reduction, which represent as desirable certain bodily expressions and attitudes towards the

breasts and, in turn, the body. This is both a discursive and a tangible construction, for it is espoused both in clinical studies, which find that a certain type of breasted expression produces healthy body image, and in the surgical production and correction of pathological or undesirable bodily expressions. Consequently, the demarcating of desirable and undesirable bodies in the name of health “explicitly justifies particular corporeal types and practices” (Metzl 2010, 3).

In the context of elective breast surgery, it is the medical and social commitment to positive body image as a healthy disposition and outcome that both necessitates and justifies the production of breasts that adhere to hegemonic notions of proportion, fit, size, and appearance. Adherence to such ideals is understood to produce or at least facilitate the production of positive and therefore healthy body image. Here, a woman’s possession or lack of this particular breasted aesthetic in conjunction with her attitude toward or perception of her adherence to this aesthetic comes to determine whether her body image is “healthy” or “unhealthy.” As was established earlier, negative feelings toward a body that does not adhere to dominant ideals of size and shape produces body image dissatisfaction and/or body image disturbance; one solution to women’s body image problems, as per the clinical literature, is to surgically produce these ideals and positive feelings. When the surgical production of aesthetically satisfactory breasts is understood to so profoundly influence a woman’s psychological health and well-being, elective breast surgery is indicative of circumstances in which aesthetics are a determinant and indicator of health. In short, to “look good” is to “feel good”: adhering to normative femininity produces a state of “health.” This has significant implications for contemporary understandings of women’s health, which becomes increasingly established by the bodily exterior (body size, shape, and proportion) and not by, for instance, fitness, energy level, subjective evaluation, or perhaps the absence of disease.

Such a discourse also summons women to invest more strongly in health care regimes and adopt certain ideas about what it means to be healthy. For example, feminist researchers have identified and critically examined discourses that signal the “healthicization” of sex as a “new rationale” for encouraging women’s frequent and/or increased participation in heterosexual activity. In their examination of contemporary American sex manuals, Krisina Gupta and Thea Cacchioni (2013) find that “readers are encouraged to engage in an almost endless variety of self-improvement and relationship-improvement oriented sex work” in the service of mental and physical health (454). These manuals, which target white, able-bodied, and middle-class women in heterosexual relationships, present regular and pleasurable sexual activity as “an important factor in the maintenance of health and wellness,” increasing women’s sexual labour (442). This discourse of healthicization emerges as a supplement to the extant narratives of sex as a biological and essential human need and a path to individual fulfillment and empowerment.

An investment in sex-for-health is also supported and enacted at the level of the individual. Engaging with young women’s first-hand narratives of heterosexual pleasure and desire, Amy Brown-Bowers et al. (2015) identified the overarching presence of a discourse of healthicization. Young women’s articulations of their engagements with relationship sex aligned with healthicization in that participants communicated that frequent sex with their male partner is both a signal of and integral to maintaining a “healthy” relationship. Young women’s narratives indicated that sex was a solution to conflict, an essential aspect of good physical and mental health, and a way to relieve stress. This overlap between health care regimes and normalizing discourses and practices—whether it is normative feminine appearance or normative sexual scripts—produces in individuals a subscription to an idealized state of health along physical, psychological, and relational axes. Also, it demonstrates the plasticity of understandings of

health in that the idea of health is shaped by a combination of social forces and patient desires and demands that correspond with the zeitgeist.

The slippage between health and aesthetics is ultimately a conversation about the indeterminacy that exists between aesthetic and functional rationales for surgery (Edmonds 2013, 237; Naugler 2009). Reconstructive procedures—or those with a functional objective—are carried out on bodily structures considered abnormal due to trauma or disease or developmental abnormality, whereas aesthetic procedures are carried out on bodies that fall within the normal range of variation (Naugler 2009). Breast reduction surgery is a particular yet little studied example in which the divide between the aesthetic and the reconstructive breaks down. Although breast reduction, as noted earlier, is primarily carried out for health reasons (alleviating pain and discomfort), surgeons still produce an aesthetic result that contains the potential to “improve” a woman’s “approximation of the narrow norms of aesthetic femininity” (Naugler 2009, 228). For instance, discussions about the impact of scarring, in both clinical discourses and patient narratives, indicates a commitment to an unblemished, smooth and attractive feminine body (Naugler 2009). Naugler (2009) argues that “the sexualized meanings of female breasts dictate that breast reduction surgery cannot be discursively reconciled with the more acceptable uses of plastic surgery techniques” (228). At the same time, breast reduction, as clinical publication and patient narratives show, is thought of as a way to produce positive body image and an improved sense of well-being. Breast augmentation is carried out for aesthetic reasons but, as seen in Chapter 3, incorporates functional concerns when patients and surgeons express a commitment to generating a healthy body image and good mental health (including an enriched sense of general well-being, improved self- and body-confidence, and a reduction in depressive symptoms). When such symptoms, indicative of poor psychological health, are thought to be

mobilized by a patient's "inadequate" breast size and/or shape, her engagement with breast augmentation surgery can be positioned as a commitment to her health.

It is important to consider, in light of the broader concerns of this project, what this slippage between health and aesthetics, curated as it is by the discourse of body image, means for female embodiment and subjectivity. In this respect, the conflation of aesthetics with health has implications for how women engage with their bodies. It shapes the production of subjectivity and shifts the determinants of women's health. Elective breast surgery, particularly when it intersects with body image discourse, flattens the distinction between health and aesthetics, or between cosmetic and functional objectives, which means that women are targeted simultaneously at the physical and psychological level: good psychological health is shaped by physical appearance, and satisfaction with physical appearance can produce good psychological health. In addition, body image discourse in particular operates to trap women between the social-cultural mandates of self-improvement and those of self-acceptance. In the contemporary Western context, women are simultaneously indoctrinated into circumstances that ask them to physically work on their bodies in the name of aesthetics but to also accept their bodies in the name of their psychological health. The repackaging of elective breast augmentation and reduction as a way to address, by altering the material body, the psychological matter of poor body image means that, when faced with such a trap, women do not have to choose between health and aesthetics, since elective breast augmentation and reduction can meet the requirements of both.

The slippage between health and aesthetics is of course not restricted to elective breast surgery. This collapse is present in various medical contexts that are both surgical and non-invasive in nature (Edmonds 2013). The case of breast cancer and breast cancer awareness are

especially relevant here, as many of the health care processes that surround breast cancer often feminize patients as well as women in recovery in order to promote the impression of their good health. Because “breast cancer places the social integrity of a woman’s body in jeopardy, restoring the feminine body [...] is a sign of victory in the war on breast cancer” (Sulik 2011, 15). In the world of breast cancer awareness, prosthetics, wigs, makeup, and a plethora of pink paraphernalia combine to communicate this victory by demonstrating that women with breast cancer remain committed to self-care and to their feminine appearance despite the presence of illness (Klawiter 2008; Sulik 2011). Traditional feminine aesthetics become an “empowering coping strategy” (Sulik 2011, 39). Even though this does not reflect reality—women often reject reconstructions and/or are not always physically comfortable in their post-reconstruction bodies (de Boer, van der Hulst and Slatman 2015; Rabin 2016; Patenaude 2012)—a woman’s commitment to dominant aesthetic expectations and ideals nonetheless demonstrates her commitment to her health.

Weight loss or bariatric surgery is another site at which aesthetics and health overlap. While weight loss surgery is carried out to reduce the supposed health risks of obesity and not for primarily aesthetic reasons, a number of follow-up procedures, such as liposuction, body contouring, and total body lifts *are* conducted with the intention of generating a more aesthetically pleasing post-operative body (Edmonds 2013). For Alexander Edmonds (2013), the entanglement of aesthetic and functional concerns in medical practice signals the emergence of “aesthetic medicine,” which aims to “fuse health and beauty,” and reflects broader “social recognition of the importance of appearance for well-being” (233-234). In elective breast surgery, when the target of surgery is body image, the aesthetic judgments made in the clinical setting “raise ethical questions about the medical status of cosmetic surgery” given that medical

“need” is determined by the degree of adherence to or deviation from aesthetic ideals (Edmonds 2013, 245). Medical procedures and treatments that target aesthetics are connected with processes of (bio)medicalization because the “institutional embedding” of aesthetic surgery not only legitimizes surgery as a health intervention but also brings that which was not previously a medical concern into the realm of medical treatment (Edmonds 2013, 243). It is important to now examine how the manner and conditions under which breast augmentation and reduction surgeries are carried out suggests that women’s bodies and body images are disciplined and regulated by (bio)medicalization.

The (Bio)Medicalization of Women’s Body Images

Medicalization “describes a process by which nonmedical problems become defined and treated as medical problems usually in terms of illness and disorders” and refers to the intensification of and/or increase in medical interventions and the ongoing discovery of new medical “problems” (Conrad 2008, 4). Early investigations of medicalization followed Foucault and conceptualized medicalization as a form of social control that aims to increase the productivity of citizens by ensuring their good health (Conrad 1992; Kohler-Riessman 1983; Zola 1972). The development of body and health norms in the 18th and 19th centuries legitimated the isolation, surveillance, and regulation of “deviant” bodies, bodily processes, and behaviours in the interest of establishing “health.” Given this connection between good health and individual productivity, medicalization is understood to be an effect of modernization. As the institutionalization of medicine came to replace traditional institutions such as the church, the medicalization of daily life was increasingly instigated in the name of “health” (Zola 1972). Processes of medicalization prompt the control and regulation of the individual by social institutions. In the contemporary context, innovations and developments that made biomedicine

more technoscientific ushered in the era of biomedicalization, which incites the individual toward self-governance, self-surveillance, and self-discipline, and transforms biomedical processes and individuals (Clarke et al. 2010; Rose 2007). The case of elective breast augmentation and reduction contains elements of both traditional medicalization and contemporary biomedicalization particularly because, considered historically and at present, women have continually been incorporated into the biomedical model through the medicalization of their bodily orientations, body practices, and body processes.³⁶

The medicalization of the size, shape, orientation, and appearance of female breasts indicates that the optimal outcome of elective breast surgery is one that aligns the breasts with aesthetic outcomes. Breasts are unequivocally medicalized in the context of breast augmentation and breast reduction, considering the many “deformities” that plague women’s breasts, as outlined in Chapter 3. Given surgeon interest in and commitment to identifying in women the aesthetic and/or functional and/or psychological pathologies that they use to justify surgical intervention, it is important to focus on how surgical discourse and practice indicate the medicalization of female breasts. First, breast reduction surgeries have long been determined by aesthetic concerns. Aesthetic surgeons perform them and these procedures fall within the realm of “plastic” (reconstructive) surgery (of which aesthetic surgery is a part) (Chao et al. 2002; Shakespeare and Cole 1997). Surgeons performing breast reduction surgeries are concerned with producing not just a more comfortable (smaller) breast size for the patient, but also one that is

³⁶ The feminist literature on this matter is far-reaching and cannot be taken up in detail. These are some key examples: Ellen Frankfort (1972) condemns the “control” of the female body by the medical and pharmaceutical establishments; Barbara Ehrenreich and Deirdre English (1973) understand hysteria as the medical management of women; Ann Dally (1991) traces the early surgical treatments to which women were subject either as test subjects or to remedy their myriad inferiorities; Virginia Braun (2005), Jennifer R. Fishman (2004), and Leonore Tiefer (1995) all identify instances of the medicalization of female genitalia and sexuality; Vicki F. Meyer (2001) examines the medicalization of menopause; Sharon Wray and Ruth Deery (2008) focus on the medicalization of body size; and, finally, Laura Mamo and Jennifer Ruth Fosket (2009) examine contraceptives that suppress menstruation as an example of medicalization.

aesthetically appealing (Sullivan 2001). The intended outcome of breast reduction is one of gendered coherence in that it is elected to reduce the stigma and self-consciousness—in addition to physical discomfort—that accompanies very large breasts (Naugler 2005). As much as women participate in and “choose” elective surgery, the medicalization of female breast size and shape is unsurprising in a context in which male surgeons establish what is and is not aesthetically pleasing and whose authority enables their judgments to be trusted by a predominantly female clientele (Balsamo 1992; Morgan 1991). The “narrow palate of pleasing looks” is common across aesthetic surgery (Weber 2005, para. 3) and is reinforced in the clinical literature as the medicalization of breasted diversity, which comes to define what the results of elective breast surgery look like. This association is significant for understanding first how the results of breast augmentation and reduction are determined and second how surgical aesthetics and bodily ideals are engaged in a continual interaction. The practitioner studies acknowledge and sometimes critique the female body ideal espoused in the media, but they then (re)produce it, both discursively and materially.

The conditions and terms under which the size, shape, and appearance of female breasts are (bio)medicalized intersects with cultural ideals about female breasts. The studies of surgeon-author discourse collected and analyzed in Chapter 3 indicate that both women and their (predominantly male) surgeons internalize ideals as expressions of physical normality (Sarwer and Spitzer 2012; Solvi et al. 2010; Beale et al. 1984). An uncritical acceptance of the “ideal” breast becomes the aesthetic objective for surgical outcomes and impacts whether patients and surgeons will assess their results as “satisfactory” or “pleasing” (Khazanchi 2006; Rogliani et al. 2009; Spear et al. 2004). At the same time, these studies place much emphasis on the importance of results that look and feel “natural” (Crerand et al. 2007; Quoc et al. 2013; Khazanchi 2006;

Sarwer and Infield 2009; Beale et al. 1984). This concern with aesthetic results is present in the literature on breast augmentation (as expected) (e.g., Khazanchi 2006) and reduction (e.g., Rogliani et al. 2009). An emphasis on the natural not only reinforces the collapse between the normal, the ideal, and natural. It also affirms a commitment on the part of surgeons to produce results that do not reveal the presence of surgical intervention.

Elective breast surgery is not solely a case in which women's bodies are subject to increasingly specific and particular processes of medicalization; it is also a site that, as the results of this study indicate, medicalize women's body images. This occurs through the pathologization of women's perception of and attitudes towards their own bodies. The possibility of the medicalization of body image is generated in and supported by the way that body image research developed. Early studies of body image examined how women were unable to perceive their bodies accurately; in turn, body image problems were marked by the presence of a perceptual defect in study subjects (Gleeson and Frith 2006; Markula 2001). However, once psychologists noticed that body image dissatisfaction and disturbance was so prevalent among women, it could no longer be supported with reference to perceptual defect, for it could not be possible that such a large percentage of the population could suffer from this defect. Researchers of body image adjusted their study objectives and methodologies as a result. They newly focused on the presence and psychological impact of dissatisfaction with one or more parts of the body, in conjunction with the role and impact of external influences, such as popular media and social forces, in order to explain the presence of women's body dissatisfaction. Kate Gleeson and Hannah Frith (2006) note that "rather than focusing on the discrepancy between the individual's actual and perceived body size/shape," researchers came to focus on the "discrepancy between individuals' perceived and ideal body size/shape" (81). This shift, they point out, "acknowledges

that one's perception and evaluation of one's own body takes place in a cultural context in which some bodies (e.g. thin, white, symmetrical, and unblemished) are more highly socially valued than others" (81-82). What developed, as a result, was a revised theory of body image problems that took into account the significance of the social realm in the development of individual body image and that recognized that forces outside the individual were relevant in forming—and explaining—how women judge and experience their bodies. Nonetheless, body image remained an individual problem with individualized solutions.

The development of body image as an intrinsic property of the individual that could be observed, measured, and tested using various instruments—among them, the Body Image Ideals Questionnaire and the Multidimensional Body-Self Relations Questionnaire—in turn created and validated categories like “normal” and “dysfunctional” body image. Once researchers identified the characteristics of pathological body image, body image could then be brought into the realm of health care. The intersection of body image with health care opened women up to participate in treatments for negative body image, such as cognitive behavioural therapy, nutrition counselling, and surgery. The concept of body image was and continues to be leveraged in order to support medical intervention into women's relationships with their bodies, which not only legitimizes women's engagement in body work but also makes this engagement a matter of health and well-being. The construction of female body image as a problem to be managed by the intervention of medical and/or health care professionals indicates the medicalization of female body image.

Finally, it is important to briefly acknowledge that, given the context in which women are motivated to and undertake elective surgery, both breast augmentation and reduction intersect with neoliberal consumerism. Despite their ostensibly oppositional intentions and outcomes,

breast augmentation and breast reduction are entangled with neoliberal consumerism, particularly as a result of the widespread marketing and direct-to-consumer advertising of elective surgery. As non- or minimally invasive aesthetic, pharmaceutical, and other treatments become routine, individuals are simultaneously seen as patients *and* customers of medical services (Clarke et al. 2010; Conrad 2005; Rose 2007). The lack of regulation over health care services, seen primarily in the US but increasingly in Canada, means that surgeons can advertise to patients and promise certain outcomes via a combination of public trust in medical professionals and strategic marketing.

The entanglement of (bio)medicalization and consumerism reveals itself in the case of breast augmentation and breast reduction surgery. Breast augmentation procedures are explicitly carried out in the realm of medical consumerism. Categorically speaking, aesthetic surgery “is driven largely by the consumer market” because “virtually all of these procedures are paid for directly out of the consumer’s pocket” (Conrad 2005, 9). Breast reduction surgeries, by contrast, are undertaken primarily for health reasons and are, most of the time, paid for not by patients themselves but by a state-level health provider (Naugler 2009); despite this, breast reduction surgeries also intersect with commercialization. As Naugler (2005) points out, “it is impossible to locate the delivery and experience of breast reduction surgery discretely as if it were about increased ‘health’ alone” (207). Women opt for breast reduction surgeries in order to feel and look more feminine; another common reason why women elect to have breast reduction is so that they can more easily shop for clothes (Didie and Sarwer 2003; Naugler 2005). This marks at least one way that breast reduction intersects with consumerism, in that it is sometimes undertaken for reasons that open up opportunities for consumption.

Breast augmentation and reduction also intersect with neoliberal consumerism in the way that patient and practitioner discourses emphasize the importance of individual choice. These two procedures are represented as instances in which an individual woman exercises her inherent “right” to “choose” what is in her best interest. Here, we see women both produced and represented as proper, neoliberal subjects in that they are self-governing, independent and possessing a seemingly endless desire for self-examination and improvement through consumptive practices (Becker 2005; Braun 2009; Clarke et al. 2010; Cruikshank 1999; Gill 2007; Moran and Lee 2016; Rose 2007). In turn, electing to undergo breast augmentation or breast reduction surgery within a “market model of medicine that responds to consumer demands” (Hurst 2009, 123) enables patients to not only “enjoy the benefits of consumerism and choice-making” (Mirivel 2008, 154) but also to affirm their autonomy (Rose 2007). “Choice” rhetoric enables individuals to affirm the legitimacy of their decisions, but it also quiets critiques and challenges of those choices (Gimlin 2000).³⁷ By contrast, in “making the choice to have cosmetic surgery, women are empowered, self-determining, and in control” (Dolezal 2010, 370); however, the available choices exist within the dominant social order (Becker 2005). The “free, contextless choice” to undergo elective surgery supports a model of jubilant individualism (Becker 2005, 129) that complements the personal management of body image, in that such an intervention focuses on correcting the personal failures of the individual rather than on challenging and changing the socio-cultural circumstances that produce body image “problems.”

³⁷ The politics of choice have long been a foremost concern in feminist theory, and has been considered at length in the feminist theoretical work on aesthetic and reconstructive surgeries. The notion of choice intersects with this project but it is not a central object of my immediate inquiry. Suffice it to say, then, that the intrinsic motivation for breast augmentation surgery in a context of constrained freedom of choice has been supported by some feminist theorists (Davis 1995, 2003) while some have critiqued the mobilization of and reliance on choice as a justification for invasive and unnecessary surgery (Braun 2009) and others have positioned choice as the expression of conformity (Morgan 1991). The notion of choice continues to figure in the most recent discussions of elective surgery (e.g., Moran and Lee 2016; Sischo and Martin 2015) and in feminist theoretical work more broadly speaking (Budgeon 2016; Gill 2007).

Ultimately, engagement with elective surgery as a route to improved and/or healthy body image offers, at best, what Dana Becker (2005) recognizes as a form of symbolic empowerment in the form of “personal fulfillment, self-esteem, relational skills, or an improved ability to cope with or adapt to familial, social, or societal expectations” (1). Interventions that take place the level of the (female) individual reinforces the entrenched sense that women’s strengths are social, our needs are personal, and our social positions are unchanging; therefore it is not only possible but also socially and politically acceptable to offer women benign rather than meaningful opportunities for empowerment (Becker 2005).

Conclusion

This chapter synthesized the findings of the previous two chapters and considered these findings against the broader concerns and context of this project. In the first part of this chapter, I examined what clinical publications about elective breast surgery and women’s narratives of their experiences of surgery reveal about women’s body images. I found that women who have had elective breast surgery articulated a broader range of experiences and outcomes, speaking both generally and in relation to body image. In engaging this comparison, I acknowledged some of the points of overlap that emerged between the clinical publications and the interviews, and I focused in particular on how different mechanisms—closed-ended questionnaires and semi-structured interviewing—produce different and distinct narratives about body image.

I also used this chapter to extend the empirico-theoretical results beyond the context of the case studies and consider their implications for the broader conceptual concerns of this project. I returned to the phenomenological problem of whether or not to render body image and body schema as conceptually distinct. The interview texts in particular indicate that, because our cognitive experiences and pre-cognitive processes exist along a flexible plane with unstable

boundaries, body image and schema can never be fully distinct. I also returned to the fact that elective breast augmentation and reduction are often carried out under the auspices of individual health and well-being, but are performed in the medical setting on a bodily site that is valued for and judged on the basis of aesthetics. With this in mind, I took up the ways that these two procedures intersect with health and aesthetics. I suggested that the motivation to instill or develop “positive” or “healthy” body image becomes a personal and professional project oriented toward ensuring that women feel happy with how they look. I proposed that the clinical discourse on elective breast surgery communicates that such happiness can in fact be achieved in the medical context through elective surgical procedures that change bodily appearance. I argued that patient motivations for and surgeon justifications of elective breast augmentation and reduction suggest a convergence of health with aesthetics: elective surgery can be carried out in the name of health when it gets intersected with an individual commitment to well-being through body satisfaction and acceptance. In this way, women are increasingly invited to work on improving their body image, but to do so in the context of professional and/or medical care.

Noting that elective breast surgery is positioned (in the literature) as a way to treat dysfunctional or pathological body image, I then considered the medicalization of women’s breasts *and* body images. I identified that in the clinical setting and in the literature, clinicians medicalize women’s breasts by attributing to them various conditions and disorders, which is established in the feminist literature, but I have argued that this literature medicalizes body image. I suggested that the long-term study and observation of body image in a research or an empirical context means that deviations from what has been established as comprising “normal” body image are identified as dysfunctional and subsequently recommended for treatment by health care professionals. Finally, considering the relationship between elective breast surgery,

body image discourse, and women's experiences of their body images, it became important to consider the broader socio-cultural context that makes such procedures possible, viable, legitimate and perhaps inevitable. To this end, I considered how breast augmentation and reduction function in a context of neoliberal consumerism that enables people to purchase "normalcy" and "health" and justify their engagement with elective surgery through an appeal to the neoliberal penchant for individualism, empowerment, and choice. In this context, there is an overarching emphasis on presenting surgery as a matter of personal choice and motivation intrinsic to the individual.

This chapter has identified some of the complexities of body image and embodiment that emerge in examinations of the manifold contexts of elective breast surgery and has demonstrated that a poststructuralist-phenomenological account can trace how embodiment and subjectivity are constituted by discourses, practices and institutions of power *and* by experience. The next and final chapter concludes the dissertation with a discussion of the significance of this project. It outlines the major empirical and theoretical findings, discusses the project's major contributions to the literature, meditates on the limitations of this project, and considers some directions for further research.

CHAPTER 6: CONCLUSION

This chapter concludes this dissertation by considering the project's main findings, contributions, and innovations. First, I summarize the major findings of the previous chapters. I then outline the contributions that this project makes to poststructuralist and phenomenological inquiry (focusing particularly on its intersections with feminist thinking on the body), to scholarship on body image, and to theorizing on the body, embodiment and body practices. I specify how this project contributes to theoretical and empirical understandings of how elective breast surgery intersects not only with experiences and constructions of the body and embodiment but also with the conceptual and tangible collapse of health and aesthetics. Then, I consider how this project contributes to thinking about the operation of power on the body and to our articulation of the lived body and embodiment. This chapter closes by outlining some of the empirical and theoretical limitations of this project and, in turn, by identifying possible directions for future research.

Primary Empirical and Theoretical Findings

This project centered on two distinct yet interrelated case studies, both of which examined how elective surgery affects women at the level of body image and how body image is mobilized and enacted in a particular biomedical and surgical context. This multifaceted inquiry produced a broad range of empirical and theoretical findings. In examining the mobilization of body image in two different discursive contexts and from two different theoretical perspectives, this project has been able to identify and elucidate varying functions of body image and body schema in the context of elective breast augmentation and reduction. On the one hand, the poststructuralist analysis of clinical publications about body image in elective breast reduction and/or augmentation revealed that the concept and phenomenon of body image is mobilized in

service of a normalizing effect because these studies and articles perpetuate the notion that elective breast surgery can produce a transformative effect on women's body image by generating—or at least facilitating—the creation of positive/healthy body image. This analysis also revealed that, in uncritically accepting the popularized notions of body image and body image dissatisfaction, the authors of these studies and articles, who are often health care practitioners, pathologize the body images of their patients—in addition to pathologizing breast diversity. This pathologization functions as a justification for surgery, which is evidenced by consistent reports of positive results and high levels of patient satisfaction. Drawing on their status as “experts,” surgeon-authors not only reinforce dominant ideas about women's breasts and body images, they also inscribe on the body what they determine to be acceptable. Overall, drawing on the feminist-poststructuralist framework to interrogate clinical discourse on elective breast surgery and body image reveals that practitioners' reliance on the popularized notion of body image creates conditions in which women are invited to participate in homogenizing measures that are reportedly transformative not only at the level of the body but also at the level of individual psychology and well-being.

On the other hand, the phenomenological study of women's first-hand accounts of elective breast augmentation and reduction surgery reveals that body image/schema functions differently at the level of the individual. Conversations with women about their experiences reveal that both their decision to undergo surgery and their experiences of elective breast augmentation and reduction are not solely about wanting to enhance their self-esteem or improve how they feel about their bodies. Notably, women's first-hand accounts of their experiences with breast augmentation and breast reduction generated rich descriptions of their pre- and post-operative bodily orientation, habit, and sensation, which is neither present in nor able to be

apprehended by clinical publications. Such results indicate that how we live in the world through the body is as relevant to women's experiences as how the body appears to women. This is a crucial finding that suggests that women's discussions of body image/schema extend beyond their ideas and attitudes towards the body's appearance and suggest a relationship with the body that privileges what the body can do, sense, and feel, alongside the possibilities that it can enact and enable.

The above summarizes the respective findings of the two empirico-theoretical studies that comprised this dissertation project. But, it is also important to consider the results of these two studies in tandem with one another along their respective theoretical axes, given that the objective of this project was to bring together poststructuralism and phenomenology in the interest of generating insights about how elective breast augmentation and reduction affect the body and embodiment in relation to body image/schema. Reading clinical publications alongside women's experiences of elective breast surgery and body image reveal that it is not the case that patient accounts manifest in stark contrast to practitioner discourse, nor is it that case that experiential accounts map exactly onto practitioner discourse. To be specific, several interview participants indicated that their diminished or compromised sense of femininity was a motivating factor in their decision to have surgery, something that is prominent in clinical accounts; however, women's understanding of femininity was not always directly linked, as it was in practitioner studies, with normative aesthetics. In turn, femininity is significant in women's decision-making, as clinical discourses indicate, but it is understood in a manifold manner than cannot be accounted for in clinical discourses.

Further, when women's contributions touched on aspects of their experience that were relevant to body image, they often expressed concerns and outcomes that paralleled the

popularized notion of body image. Several participants expressed a pre-operative sense of disproportion between the parts of the material body as well as between their material bodies and their internal images of their bodies; they contrasted this with a post-operative experience of proportion between body parts and between perception and reality. The articulation of this shift from an experience of disproportion to one of proportion is also reflected in clinical studies. Therefore, the role of femininity as a motivating factor alongside experiences of (dis)proportion are but two examples that suggest that aspects of women's experiences do align with what is captured in the quantitative questionnaires. This makes sense given that clinicians' surveys and questionnaires are also tracking women's experiences, even if they do so selectively and problematically. At the same time, as noted above, the narratives offered indicate that their pre- and post-operative experiences extend far beyond that which is and can be accounted for in clinical discourse.

Ultimately, although many women were indeed compelled to pursue elective breast augmentation or reduction in accordance with the normative motivations articulated in clinical publications—to improve their bodies, to alleviate their depression, to become more extroverted, to enhance their sense of femininity, to reduce physical discomfort—their experiences were also caught up in how they newly came to act upon the world and in the world as a result, through sport, intimacy, and work, which signals a (re)negotiation of their agentic potentiality. In bringing both poststructuralist and phenomenological inquiry to bear on the study of the effect of elective breast surgery on body image, the most significant finding of this dissertation is that it can attest to female embodiment and subjectivity as “both discursively constructed and experientially relevant” (Levin 2008, 168).

Project Contributions and Innovations

This project contributes to various lines of inquiry in poststructural, phenomenological, and feminist studies of the body, both individually and at the intersections of these interdisciplinary frames. In bringing together poststructuralism and phenomenology, this project has made possible an analysis of embodiment that dually considers the micro and macro levels of experience alongside the interplay between technologies of power and the lived body. The findings of this project demonstrate that a poststructural-phenomenological framework can simultaneously account for how women experience bodily change through elective surgery not only as an experience situated within a biomedical context informed and shaped by normativizing discourses of power but also as an embodied reflection upon the body's materiality, spatiality, and temporality. While there have been many calls for feminist research that brings together poststructuralism and phenomenology in the analysis of women's experiences (Cosgrove 2000; Dolezal 2010; Stoller 2009, 2010), there are actually very few studies of this kind in the feminist literature (Heyes 2007a; Levin 2008). Therefore, following extant feminist thinkers who work to reconcile the supposed tensions between poststructuralism and phenomenology (e.g., Alcoff 2000; Dolezal 2010; Heyes 2007a; Levin 2008; Oksala 2004, 2016; Stoller 2009, 2010), this project enfolded poststructuralist and phenomenological concerns and, in turn, offered an ideological critique of elective breast surgery and body image alongside a disclosure of the experiential and lived impact of elective breast surgery on body image.

The analytical joining of poststructuralism and phenomenology, guided largely by the insight of their feminist allies, has produced a project that contributes to these fields both individually and in their respective intersections with feminist research. A major contribution that this project makes to feminist poststructuralist thinking on the body is that it reveals that

elective surgical intervention is carried out on both physical and non-physical terrain. Feminist theorists have long tracked the ways that elective surgery constantly expands in order to operate upon new and ever-more-minute bodily territory (Morgan 1991; Tiefer 2008); this study demonstrates that elective surgery also intervenes on body image and, in turn, psychological well-being and that this territorialization is worthy of further examination. This dissertation project generates for feminist poststructuralists an awareness of body image *and* body image discourse as technologies of power, because it demonstrates that body image is a concept leveraged in the justification of elective surgery and a psychological state subject to biomedical intervention.

This project also contributes to feminist phenomenology of the body and phenomenological inquiry on body image/schema. The inquiry into how women articulate the ways that they feel, do and engage with their bodies in the world after elective breast surgery affirms the findings of previous theoretical work on body image that suggests that our body images are plural and continuously shifting and reformulating (Schilder 1950; Weiss 1999). The articulation of women's experiences of elective breast augmentation and reduction revealed that surgical change to the body instigates a dissolution of body image that necessitates its reconstitution—what I earlier called a “relearning” of the body and the world. In charting women's focused articulations of the materiality and everydayness of bodily experience, this project responds to Weiss's (1999) call for theorizations of body images that refuse to privilege transcendence over immanence. Specifically, the phenomenological inquiry into women's experiences of body image focused for example on sensation and touch, which in turn centered the immediacy and primacy of women's bodily experiences. This offers a contrast to narratives of body image/schema premised upon psychological transformation.

Most significantly, the findings with regard to how elective breast surgery impacts women's experiences of the lived body not only identifies and examines the importance of articulations of shifting body images/schema, they also open up the possibility to, in contemporary phenomenology, rethink the conceptualization of body image and schema as distinct phenomena and concepts. Often, body image is often theorized as being separate from but overlapping with body schema, as noted earlier. Women's first-hand descriptions of how elective breast surgery instigated changes in how they engage with their bodies in the world suggests the possibility that, because our bodies are continuously changing and because shifting body images is our default embodied condition, we exist in an ongoing, embodied negotiation between our motor and sensory systems and our perceptions, actions, and attitudes. Phenomena like surgery, which oftentimes fundamentally changes the body's orientation and galvanizes, as this project shows, embodied regeneration and bodily rehabitualization, is but one bodily experience that suggests that the boundary between our conscious and preconscious systems is readily and continuously dismantled and rebuilt. Upon such disturbances, traumas, or illnesses, the body and/or its functions fail to "dys-appear" into the background of our experiences and summons us to attend to it (Leder 1990). Women's narratives show that such procedures spur attempts to dys-appear the body, and suggest that perceptions and postures and our motor and sensory abilities are perhaps not as categorically distinct (conceptually or phenomenologically) as sometimes thought. Furthermore, because this negotiation between motor activity and perception becomes apparent when it is articulated in language, it is language that makes our preconscious system and activities articulable and therefore conscious (Weiss 1999).

Furthermore, this project also makes inroads into the various points of inquiry with which it has intersected. It has worked to contribute to ongoing points of interest in poststructuralist and

phenomenological critiques of biomedicine. Through an exploration of the effects of elective breast surgery on female body image, this project has been able to attend to and engage with the biomedicalized health care context and conditions under which such surgeries are carried out. As discussed in Chapter 2, biomedicine has been critiqued both by poststructuralists who see biomedicine as an institution of power that produces compliant subjects and normativized bodies (Bordo 2003; Lupton 2003; Rose 2007) and by phenomenologists who challenge biomedicine's failure to account for the patient. Although these two frameworks have for three decades generated productive insights into the operation and effects of biomedicine on patient outcomes and experiences (Carel 2011; Carel and Kidd 2014; Leder 1990; Toombs 1992, 2001), and even though poststructuralists and phenomenologists agree that biomedicine decontextualizes, objectifies and alienates patients (Mazis 2001), they rarely examine biomedical discourse in tandem with patient narratives. In bringing together a critical analysis of practitioner discourse with the expression and disclosure of patient narratives, this project has captured the effects of elective breast surgery on female bodies, body experiences, and embodiment both as they are articulated in discourses and institutions of power *and* as lived-through in everyday experience.

This project also contributes to feminist theorizing of the body, embodiment, and body practices. As I noted in the Introduction, feminist theorists have, since the 1990s, offered a range of analyses of the effects and significance of elective surgery for how women understand and make sense of themselves as embodied subjects. Most of these studies were undertaken from a poststructuralist perspective and emphasized the oppressive effects of elective surgeries on female subjectivity. Feminist theorizing on elective surgery established, drawing on theorizations of aesthetic outcomes and popular media discourse, that aesthetic surgery encourages women to “choose” conformity, makes women see themselves as “defective,” makes them even more

vulnerable to the patriarchal gaze, and standardizes the technological “improvement” of the female body (Bartky 1990; Bordo 2003; Morgan 1991; Negrin 2002; Tait 2007). These initial feminist analyses of elective surgery were soon critiqued by feminists who thought that such understandings made assumptions about the nature of women’s participation in aesthetic surgery without engaging with actual women about their motivations (Davis 1995). Subsequently, a number of feminist studies emerged to account for women’s first-hand engagements with aesthetic surgeries and allow women themselves to articulate not only their motivations but also the effects of surgery (Davis 1995, 2003; Gimlin 2002; Pitts-Taylor 2007).

This project contributes to feminist studies of aesthetic surgery by offering women’s first-hand accounts of their experiences with surgery, but it extends this dialogue beyond mere questions of identity, the alleviation of suffering, or the acquiescence to normative aesthetics. By attending to the phenomenological notion of body schema when in conversation with women who undergo breast augmentation and reduction, this project asked different questions and thus drew unique conclusions about how women live as embodied subjects, in addition to contributing to discussions about attitudes toward the body. Specifically, this project moved beyond a focus on how surgery affects body image (in the mainstream sense) and well-being and instead engaged with how surgery changes our everyday experience of the world through our bodies. In finding that surgery provokes shifts in embodied doing in terms of spatiality, intentionality, and sensation, this project is especially significant for studies and understandings of embodiment, for the findings indicate that attention to the phenomenal body is a productive direction in which to take feminist studies of aesthetic and/or elective surgery.

This dissertation also contributes in several ways to the understanding and study of body image. This project engaged critically with the notion of body image in the context of elective

breast surgery and, via theoretical analysis, revealed some of the implications of the reproduction of mainstream body image discourse. Rarely is the concept of body image critically evaluated by researchers, practitioners, or theorists. Instead, body image is assumed to be real, to have a consistent meaning and significance for people, and to be something that can be tangibly evaluated through a combination of questionnaires and observation (Blood 2005; Gleeson and Frith 2006). This project did not set out to evaluate the legitimacy or validity of body image as a concept or to critique the design of the studies; instead, my primary objectives in this regard were to reveal how the concept of body image is mobilized in clinical discourses on elective breast surgery, to identify the discursive effects of this mobilization, and to consider whether new conclusions might be drawn if our studies of elective breast surgery moved away from an uncritical acceptance of the dominant notion of body image and toward its phenomenological counterpart. Engaging in such a study, as this dissertation has done, offers several important contributions to the study of body image in the context of elective breast surgery.

First, bringing together the dominant notion of body image with the phenomenological notion of body schema offers a fuller account of body image that focuses not only on mental or internal representations of the body but also on how we live in the world through our bodies. This dissertation offers an account of women's experiences with elective breast surgery and draws on them to suggest that such procedures affect not only mental perception of bodily appearance but also our bodily motility, spatiality, and habit and our awareness of these phenomena. In turn, the empirico-theoretical studies that comprise this dissertation reveal that elective breast surgery affects more than women's mental perceptions of and attitudes towards our bodies—it also changes how women engage in embodied doing. Attention to the phenomenological notion of body schema, particularly when disclosed through women's first-

hand accounts of surgery, suggests that elective surgery impacts women's felt sense of the body as much as it does their ideas about their bodies; it also shows how these work in tandem in the formulation of embodiment. It is imperative to call not only for a theoretical reconsideration and rearticulation of body image but also for a complexification of how we study body image, in the context of elective surgery but also in the context of female body practices writ large (e.g., disordered eating, dieting, body modification).

Second, and crucially, the popularized and phenomenological articulations of body image have yet to be thought together in a sustained way. As noted in the above summary of project findings, reintroducing the phenomenological notion of body image/schema to its mainstream counterpart, as this project has done, opens up the possibility to think anew and think differently about what body image might be and might mean for individuals. This dissertation has demonstrated that attention to the phenomenological notion can contravene popular notions that a) body image is built upon self-esteem and self-confidence, which originate solely in an idea or image that people have of themselves; and b) body image comes from this image and not from a felt sense of the body.

Finally, this project instigated a comparative study of breast augmentation and breast reduction surgery, two procedures that, although performed on the same bodily site, are supposedly carried out for distinct reasons. In engaging in this comparison, this project responds to the relative lack of theoretical attention given to the intersection between the aesthetic and the reconstructive in the context of surgical practice. This project examined what Naugler (2009) calls the "aesthetic/reconstructive divide" by focusing on the function of discourses of health and normative aesthetics in the context of these two procedures. Critical engagements with surgery, whether historical, theoretical, or empirical, have mostly overlooked any engagement with the

connections and tensions that exist between the seemingly divergent categories of surgical procedures; that is, between aesthetic surgical procedures and reconstructive surgical procedures.

Few investigations of surgery place aesthetic procedures into a productive dialogue with medically necessary ones, despite the fact that many surgical procedures traverse and in turn complicate these boundaries. Reconstructive surgeries—those thought to improve physical function or physical well-being—and aesthetic surgeries—those considered to enhance appearance according to a set of culturally determined aesthetic standards—are implicitly understood via divergent sets of questions and are represented as producing distinct embodied effects. As a consequence, the tensions and connections between them remain undertheorized and are too infrequently the subject of critical theoretical and/or empirically grounded analysis.

This project responds to this conceptual and empirical gap by bringing breast augmentation and reduction into the same conversation. In this case, that conversation has been about the meanings and significances of body image and body schema in the technical and lived context of these two procedures. This project has demonstrated that, on the one hand, clinical discourses on elective breast augmentation and reduction suggest that these procedures generate transformations in body image that improve confidence and self-esteem and that, on the other hand, women's first-hand accounts of body image suggest a different kind of outcome in the form of a "relearning" of the world. This finding demonstrates that, whether we are talking about transformations in body confidence or renegotiation in/of embodied doing, elective breast augmentation and reduction are actually similarly understood by the clinical context and similarly lived (as far as they are concerned vis-à-vis body image, at least). Therefore, it is possible to suggest that the aesthetic/reconstructive divide is far less stable than it is understood to be in the context of the provision of health care resources. Furthermore, in finding that the

impetus and outcomes of both elective breast augmentation and reduction appeal to contemporary notions of health and aesthetics, I have also demonstrated that the discourse and practice of both of these procedures reveals a slippage between health and aesthetics, in that these procedures are carried out under the assumption that a strong aesthetic outcome will have a positive impact on the patient health by producing positive body image. Such a finding reveals that the aesthetic aspect and the reconstructive—or health-centric—aspect of elective breast surgery exist in a state of overlap.

Limitations and Directions for Future Research

Overall, the goal of this project has been to examine the relationship between elective breast surgery and discourses and experiences of body image, investigating what happens when elective surgery intervenes in women's body image(s). Throughout, this project has worked to elucidate and make sense of the conflicts and tensions that the routinization and everydayness of elective surgery institutes between mind and body, private and public, reconstructive and aesthetic, and phenomenological and poststructural inquiry. The empirical and theoretical findings, as summarized above, are particularly generative in light of the limitations of extant studies, yet the aims and scope of the present project are also limited in several ways, as outlined below. At the same time, some of these limitations are useful in signaling points of departure for future research.

The scope of this project is first limited by the practical matters of study design and execution. A limitation of the study as a whole is that it does not use the clinical publications or interview texts to critically examine whether or not body image is in fact a productive way to understand the outcomes of elective surgery or women's experiences thereof. In turn, this study could have attended more closely to problematizing the notion of body image in clinical

publications in particular in order to assess whether body image is a legitimate measure. Such work has been done already and well elsewhere, as noted above (Blood 2005; Gleeson and Frith 2006); on the other hand, by not taking a more critical perspective on the validity of body image/schema as a concept, this project risks reifying body image and reproducing some of the same assumptions that others have identified as problematic. Further, the poststructuralist analysis of clinical discourses of elective surgery is perhaps limited by its focus on a qualitative examination of the texts. The analysis of the texts would be enhanced by a quantitative engagement that could demonstrate the precise trends in the discourse both on the whole and over time. A quantitative study would enable the examination of a larger data set and could also more precisely track the prevalence of prominent themes in the discourse.

The phenomenological inquiry of women's experiences of elective breast augmentation and reduction is also limited by certain methodological and conceptual factors. An immediately apparent limitation is that of the small and narrowly diverse sample—although participants were diverse in terms of sexual orientation, age, size, and ability, the majority are white, educated urbanites economically situated in the lower-middle or middle class. Further, in order to more fully account for how elective breast surgery impacts women at the level of body schema, it would be particularly productive to follow women throughout the entirety of their journey—from decision-making to recovery—in order to generate a more comprehensive account of the lived effects of elective surgery. Such a study could open up the potential for a multiple-methods approach in which conversations with participants could be both many instead of singular and supplemented by the inclusion of participant diaries or artworks, interviews with health care practitioners, and, most significantly, interacting with participants as they do their bodies in real time. Although studies that incorporate one or more of these elements have in fact been

conducted (e.g., de Boer, van der Hulst, and Slatman 2015; Slatman et al. 2016), they are difficult to develop without access to a clinic and/or a hospital that is willing to help researchers connect with patients. They also require a great degree of time in the field and tangible research support, both of which are typically unavailable to graduate students.

Another limitation of this study can be identified when we consider the way that this study has worked with phenomenology as a methodology. This study used semi-structured interviewing and thematic analysis to gather, analyze, and disclose women's accounts. While interviewing is frequently used in phenomenological studies and is a suitable method given the time and funding constraints mentioned above, there are also problems with trying to phenomenologically account for experiences by disclosing them in language. Notably, subjectivity is produced by language and is thus "not the reflection of an innate or essential individual consciousness (the "individual" at the centre of body image investigations), but is...constructed through language in ways that are socially specific" (Blood 2005, 48). Although it has not been my intention to use phenomenology to counter biomedical discourses of body image by disclosing the "truth" of women's experiences or "essence" of female embodiment, it is nonetheless important to acknowledge that the interview texts themselves are produced in, subject to, and constrained by the social structure.

Although this study was limited by the above conceptual elements and practical matters, these limitations indicate how this study might be opened up and extended in order to generate additional research. The phenomenological aspect of the methodology of this project is located more so in its commitment to phenomenological themes and concepts and less so in the research process, which would have benefitted from taking on the research as a form of "being with" rather than "doing to" participants (Finlay and Payman 2013). The study of women's first-hand

accounts might be broadened by increasing the sample size in order to generate a more diverse group of respondents; such a study could also be planned to include more time in the field so as to generate an account that captures the full range of the experience of elective surgery.

Beyond merely expanding the limits of the extant study, there are three points at which the empirical and theoretical contributions and innovations of this project can serve as a productive point of departure for the development of additional research. First, the unique and salient findings about how elective surgery impacts bodily orientation, habituation, and sensation suggest that there is more to be uncovered in this regard about female body experience. Additional feminist phenomenological and feminist poststructuralist inquiry ought to continue to expand the boundaries of how and in what contexts we study “female body experience” and continue to create theoretical and empirical studies that account for how women understand what we can do with our bodies—in investigations of what we might call “embodied possibility”—as a supplement to studies that examine how we make sense of and deal with our bodily aesthetics. Such studies are emerging, particularly in feminist sport studies and feminist phenomenology of sport (e.g., Allen-Collinson 2011; Burrow 2016; Chisholm 2008; Markula 2005; Sailors et al. 2016) but they risk being marginalized in feminist theory, particularly with the rise of new feminist materialisms. Second, it would be productive to engage in further theoretical investigation that draws on the empirical findings to offer a more sustained critical engagement with extant conceptualizations and mobilizations of body image, as outlined in this study, and propose a revised theory of body image. For the sake of women who are continuously interpellated by body image, we need not only more studies that challenge the entrenched notion of body image, but we also need a new theory of body image.

A final point upon which the findings of this study can generate additional inquiries lies in the development of feminist poststructuralist-phenomenological studies that focus on the routinization of elective surgery in the contemporary West. Elective surgeries, both aesthetic and reconstructive, continually absorb the sedimented meanings and values of modern society. Additional studies of the function of elective surgery in contemporary Western culture ought to focus more closely on how our engagement with surgery changed after practitioners modernized and established it in the 20th century as a safe and routine aspect of medical care. Future studies ought to consider how elective surgery, whether aesthetic or non-emergency in nature, generates “the body” as an entity malleable to the demands of society, culture, sexuality, and economics, constitutes and reinforces hegemonic conceptualizations of the body and embodiment, and enables people to understand themselves as actively determining, on their own terms, the trajectory of their lives. This dissertation has examined this matter in the context of elective breast surgery, and it ends by calling for additional and more sustained inquiries into how now-routine surgical modification of the body has been profoundly influential in terms of how we, as subjects *and* bodies, live our lives, manage our selves, and understand our possibilities.

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APPENDIX A: INTERVIEW PROTOCOL

Interview Questions: “Understanding Women’s Experiences of Breast Surgery”

1. Tell me about what led to your decision to have surgery.
 - a. Who was responsible for making the decision that you have surgery?
 - b. Did you consult with anyone in particular about the decision (e.g., medical personnel; counselor; friends; family; significant other)? Tell me a little bit about those conversations.
2. How would you categorize the procedure? Was it cosmetic, medically necessary, both or neither? Why?
3. Tell me about how you feel about the results of your surgery.
4. Do you think that surgery has changed your body? Do you think it has changed how your body feels to you or your relationship to your body? Tell me about how any changes have impacted your everyday experience.
5. Tell me about whether surgery has changed how you feel as a woman or what you think about being a woman or about femininity. What, if anything, has changed and how?
6. How has your surgery has changed how you relate with other people? How has it changed how other people (e.g., friends, family, strangers, sexual partners, significant others) relate to you? If so, describe these changes for me. If not, why not?
7. Describe, in as much detail as you can, the circumstances surrounding your surgery.
 - What did you do to prepare for the procedure?
 - What can you tell me about the day of your surgery?
 - How long were you in the hospital/clinic? Did you experience any complications as a result of surgery? Describe these for me.
8. Please tell me about your interactions with medical personnel from the earliest discussions of surgery until your medical care ended.
 - What was your relationship with medical personnel like?
 - Can you describe their attitude toward you and your surgery?
 - Did they keep you up-to-date on what was going on?
9. Describe for me your recovery period and process. What was it like?
 - What kinds of activities were required/mandated and for how long? What were these like?
 - Did others participate in your recovery? If so, how did they participate and what was that like for you?

Participant Questionnaire

Participant’s name: _____

Preferred gender pronoun: _____

Type of surgical procedure you had: _____

Date the procedure took place: _____

Was the procedure conducted in a hospital or private clinic?: _____

Your age at the time of the procedure: _____

Your age now: _____

APPENDIX B: INFORMED CONSENT FORM

Research Study: Understanding Women's Experiences of Breast Surgery

Researcher: Sara Rodrigues, PhD Candidate, Graduate Program in Social and Political Thought, York University

Purpose of the study: The purpose of this study is to explore how and in what ways bodily changes created by breast surgery affects the sense and awareness that women have of their body and body image. Using interviews with adults who identify as female, the study aims to understand how the creation of different categories of surgery, such as cosmetic surgery and reconstructive surgery, inform or influence how women understand and experience breast surgery. The results of this study will be used in my dissertation project, as well as in conference papers and journal articles.

What you will be asked to do in the research: You will be asked to complete a short questionnaire and to respond to a series of questions that allow you to describe your experience with surgery, including: the circumstances surrounding your surgery (i.e., why surgery was conducted; what kinds of interactions you had with health care practitioners; what your recovery process was like) and your thoughts on how having surgery has changed or affected your relationship to your body and your sense of self. The interview process will take approximately one hour. This time commitment is flexible: the interview can be shorter, and if you wish to talk for more than an hour that will also be acceptable.

Risks and discomforts: Some of the questions in this study may provoke feelings of discomfort, embarrassment from personal questions, triggers of past or current trauma, or possible stress to self-confidence. Given that breast surgery is undertaken for a range of reasons, for some participants some of the questions may bring up issues around gender transition. If applicable, it is at your discretion whether you address gender transition and the extent to which you address it. You are free to decline to answer any questions in whole or in part. You may end your participation in the study at any time, with no need for explanation if you do not wish to provide one. You will be given the opportunity to review the interview transcript for accuracy or second thoughts.

Benefits of the research: By participating in this study, you will have the opportunity to speak about your experience of having undergone surgery with emphasis on how that experience has changed or affected how you feel about your body and self. I hope you will enjoy contributing to this study and having the opportunity to share your experience and perspectives.

Voluntary participation: Your participation in the research is completely voluntary. You may stop participating at any time.

Withdrawal from the study: If you so decide, you may discontinue your participation in the study at any time and for any reason. Your decision to stop participating, or your refusal to answer particular questions, will not affect your relationship with the researcher, York University, or any other group or person associated with this project. In the event that you withdraw from the study, all associated data collected as a result of your participation will be destroyed.

Confidentiality: The personal information of study participants will be held in confidence. Your identity and any identifying information will, if you wish, be rendered anonymous in the dissertation as well as in any conference papers or journal articles that result from the study. All efforts will be made to ensure that the interview data is not associated with identifying information. All interview data (handwritten notes; audio recordings) will be digitized, encrypted, and stored on a password-protected laptop to which only I have access. Data will be stored for five years after the research and writing process. After the data retention period has elapsed, the electronic data will be destroyed using Eraser (an open-source software that destroys electronic data by overwriting the files multiple times).

Questions about the research? If you have any questions about the research in general, or your role in the study, you may contact me. This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the

study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University.

Legal rights and signatures: “I, _____, consent to participate in the study ‘Understanding Women’s Experiences of Breast Surgery,’ conducted by Sara Rodrigues. I understand the nature of this project and I wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.”

I, _____, consent to have my first name published in the dissertation and/or in any conference papers or journal articles that result from the study.

Signature of Participant

Date

Signature of Principal Investigator

Date

APPENDIX C: ETHICS APPROVAL



Certificate #:
046

STU 2014 -

Approval Period: 05/07/14-

Memo

To: Sara Rodrigues, Social and Political Thought - Graduate Program,

**OFFICE OF
RESEARCH
ETHICS**

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Duff Waring, Chair, Human Participants Review Committee)

Re: Ethics Approval

(ORE)

Understanding Women's Experiences of Breast Surgery

5th Floor,
Kaneff Tower,
4700 Keele St.
Toronto ON
Canada M3J 1P3

I am writing to inform you that the Human Participants Review Sub-Committee has reviewed and approved the above project.

Should you have any questions, please feel free to contact me.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM
Sr. Manager and Policy Advisor,
Office of Research Ethics